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OVERSIGHT ON CONSTRUCTION OF VETERANS' ADMINISTRATION MEDICAL FACILITIES

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HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

MARCH 26 AND 27, 1985

Printed for the use of the Committee on Veterans' Affairs

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CONTENTS

TUESDAY, MARCH 26, 1985

Page
Opening statement of Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs 1

Testimony of:

- Hon. Paul S. Sarbanes, a U.S. Senator from the State of Maryland 15
- Dr. John W. Ditzler, Chief Medical Director, Veterans' Administration, Washington, D.C., accompanied by Dr. John Gronvall, Deputy Chief Medical Director; and Richard P. Falco, Acting Director, Facility Engineering Planning and Construction Office 21
- Paul S. Egan, deputy director, National Legislative Commission, The American Legion, accompanied by Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission 67
- Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States, accompanied by Frederico Juarbe, director, National Veterans Service 90
- A panel of representatives of veterans' organizations consisting of: David W. Gorman, assistant national legislative director for medical affairs, Disabled American Veterans; and Bob Moran, associate legislative director, Paralyzed Veterans of America 110

Written statement of:

- Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota 14
- Hon. Charles McC. Mathias, a U.S. Senator from the State of Maryland 18
- Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania 35
- Dr. John W. Ditzler, Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration 42
- Paul S. Egan, deputy director, National Legislative Commission, and Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, The American Legion 74
- Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States 96
- David W. Gorman, assistant national legislative director for medical affairs, Disabled American Veterans 112
- Bob Moran, associate legislative director, Paralyzed Veterans of America 134

Questions and answers:

- Response to questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, from:
  - Veterans' Administration 55
  - Paralyzed Veterans of America 153
- Response of the Veterans' Administration to written questions submitted by Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota 64

Letters to:

- Harry N. Walters, Administrator of Veterans' Affairs, from the chairmen and ranking minority members of the Senate and House of Representatives Veterans' Affairs Committees, dated January 2, 1985 6
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans' Affairs, dated February 7, 1985 8
- Harry N. Walters, Administrator of Veterans' Affairs, from Members of the U.S. Senate and the U.S. House of Representatives from the State of Maryland, dated March 6, 1985 9

Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from R. E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, The American Legion, dated March 28, 1985 ..... Page 88

WEDNESDAY, MARCH 27, 1985

Opening statement of Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs 159
Testimony of:
- Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama 162
- Hon. Lloyd Bentsen, a U.S. Senator from the State of Texas 181
- Hon. Phil Gramm, a U.S. Senator from the State of Texas 188
- Dr. John A. Gronvall, Deputy Chief Medical Director, Veterans' Administration, accompanied by Richard P. Falco, Acting Director, Facility Engineering, Planning and Construction Office; and Susan Livingstone, Associate Deputy Administrator of Logistics 244
- Dr. O. David West, director, special projects, Hospital Corp. of America, Nashville, TN, accompanied by Tom Batey, vice president, planning and construction 267

Written statement of:
- Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota 161
- Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama 167
- Hon. Lloyd Bentsen, a U.S. Senator from the State of Texas 184
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 195
- Dr. John A. Gronvall, Deputy Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration 251
- Dr. O. David West, director, special projects, Hospital Corp. of America, Nashville, TN 280

Questions and answers:
- Response of the Veterans' Administration to written questions submitted by:
  - Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs 292
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 257
  - Hon. Robert T. Stafford, a U.S. Senator from the State of Vermont 260
  - Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama 261

APPENDIXES

Letters to:
- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans' Affairs, dated March 20, 1985 287
- Harry N. Walters, Administrator of Veterans' Affairs, from Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, dated May 6, 1985 288
- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from Donald L. Ivers, General Counsel, Veterans' Administration, dated June 5, 1985 291
- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans' Affairs, dated June 25, 1985 304

Senate Committee on Veterans' Affairs, May 24, 1984 resolution on approval of fiscal year 1985 VA replacement/modernization construction projects and statement of views 204
Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities—Executive Summary, Booz, Allen & Hamilton Inc 305
Public Law 99-166 317

OVERSIGHT ON CONSTRUCTION OF VETERANS' ADMINISTRATION MEDICAL FACILITIES

TUESDAY, MARCH 26, 1985

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:41 a.m., in room SR-418, Russell Senate Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Chairman Frank H. Murkowski, Senators Alan K. Simpson, Strom Thurmond, Arlen Specter, Alan Cranston, George J. Mitchell, and John D. Rockefeller IV.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman MURKOWSKI. Good morning. We will call the hearing to order, the Veterans' Affairs Committee hearing on VA medical facilities construction.

I want to welcome Senator Sarbanes who will be our first witness. Senator Mathias has been delayed.

I want to acknowledge my colleague Senator Alan Cranston, the ranking minority member of the committee. And I want to welcome the newest member, John D. Rockefeller IV. Good morning. It is certainly a pleasure to have you with us on the committee. And I might add that you fill the shoes of an extraordinary and outstanding statesman, Jennings Randolph, who has been on this committee since I think almost the beginning. Senator Cranston may be able to affix an appropriate date to it.

Senator CRANSTON. Well, he was a member of this committee when it was created.

Chairman MURKOWSKI. So that was a long time ago, John. And we hope that you are not on the committee when it ends, but in any event, we do welcome you. And we will be joined by others throughout the morning.

I want to welcome also Dr. John Ditzler and his fine colleagues at the VA who will be addressing us shortly. I also welcome the representatives of the veterans' service organizations, who will be attending this hearing.

The purpose of today's hearing is to examine VA policies which impact directly on the construction program. And as a consequence of the budget restrictions, we are almost in a catch-22 situation on the particular issues of what we can fund, what the obligation is, and what the future holds.

Tomorrow the committee will consider specific issues related to the construction planning process. The VA is a significant and high-quality part of our country's capacity to provide health-care services. The VA currently provides care in VA facilities and through sharing agreements with the Department of Defense and through fee basis arrangements.

However, health care in our country is changing, as we all know. The population is aging. Medical technology for diagnosis and treatment is advancing constantly. Noninstitutional forms of care are being increasingly relied upon and a variety of cost containment policies are being explored and implemented.

In our Nation today, many VA hospitals are in need of replacement or modernization. It is therefore the responsibility of the Congress to ask an important question: How can the VA most equitably distribute limited construction resources and best serve those areas most in need of hospital beds?

Changes in policy regarding VA health care have been proposed. How will the VA integrate these changing policies, changing veterans' needs, and advances in modern technology into the construction planning process? And what impact will this have on other Federal agency health-care delivery systems? Most specifically, how will this affect the future size, the scope and shape of the VA construction program?

We must no longer base our planning on past utilization. Obviously, that is inadequate. We must ask if this is the appropriate time to consider changes in policy and changes in health-care delivery in our VA planning process.

The key question today is with an expanded demand against a backdrop of diminishing resources, what is a realistic VA Medical Facility Construction Program for fiscal year 1986 and beyond? I would hope that our witnesses would address these subjects, by outlining, in particular, the crucial problems that we have, and the projected problems due to increased need coupled with the dilemma of limited financial capacity?

I would ask Senator Cranston for an opening statement at this time and look forward to you bearing with us, Senator Sarbanes, and we will move right along here.

I have two other hearings today, one that I am supposed to chair at 11 o'clock. So we will just see how things go.

Senator CRANSTON. Thank you very much, Mr. Chairman.

Chairman MURKOWSKI. Please proceed.

Senator CRANSTON. Good morning and welcome to each and all present.

My position regarding the importance of the VA health-care system is abundantly clear and on the record. I am wholeheartedly committed to the maintenance and continued development and improvement of an independent VA health-care system. I led the effort in the Senate for the enactment of section 409 of Public Law 97-306, the provision of law which reaffirmed the policy of the United States that the VA "maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans."

This is unquestionably the right public policy and I remain unswerving in my support of that position.

First and foremost, that policy is correct, I am convinced, because there is no better way for the Nation to meet its obligation to those veterans disabled during their service than through the existing VA system.

The VA system also plays three vitally important subsidiary roles in service to the entire Nation: First, as the principal backup to the health-care capacity of the Department of Defense in time of war or other armed conflict; second, as a major sponsor of important medical research efforts of benefit to all Americans; and, third, as a very significant resource for the training of health-care personnel.

The VA could not carry out its service-connected responsibilities nor perform its important subsidiary roles efficiently or cost-effectively if it did not provide care to very substantial numbers of non-service-connected disabled veterans.

In addition to these factors, the VA system and other elements of health care in this country are interrelated and that relationship must be fully taken into account when determining policy for either sector. Any significant change in the numbers of veterans receiving care from the VA would have a direct impact on other health-care providers and on medicare and medicaid expenditures. These considerations must be fully explored before any such changes are agreed upon.

However, believing in the VA health-care system as I do does not blind me to the fact that unlimited resources are not available for it. As these hearings commence, it is clear that we are all operating with a very keen awareness of the fiscal year 1986 budget and of the efforts within the Congress and the administration to restrain Federal spending so as to begin to curb the enormous, escalating projected deficits that we are facing.

However, as significant as our immediate concerns are about fiscal year 1986, the coming year is not one extraordinary year after which we can look forward to a restoration of business as before. Rather, I am convinced that severe concerns about the Federal deficit will be with us into the foreseeable future. Those concerns will certainly directly affect all actions relating to the VA health-care system between now and the end of the century. It is vital, therefore, that this reality of continuing scarce resources be kept in mind as we seek to develop a reasonable plan for the short- and longer-term future of the VA health-care system.

Regarding the VA's construction process, I am convinced that, given the tremendous competition for Federal funds, the VA is proposing to undertake major replacement and modernization projects that are too large. Making larger-than-necessary investments in a relatively few projects over the next few years will be unwise if such actions delay—as I am certain they will—other, smaller construction projects which are needed but will go unfunded. A preferable alternative is to help more veterans more efficiently, through greater numbers of medium-sized facilities and to spread construction funds more equitably throughout the system.

That is why I have urged the VA to reexamine its major replacement/renovation bed-sizing criteria. Indeed, this committee unanimously urged that approach, in vain, last May.

Another major concern is the process for planning how the VA will carry out its various health-care missions. Far too frequently, all effort has focused on very short-term considerations. The coming impact of the aging veteran population and the pressing scarcity of resources, among other factors, have required that more attention—through the MEDIPP process and otherwise—be paid to potential future demand and how the VA system might respond to it. The recent VA report, "Caring for the Older Veteran," and the CBO analysis on the same issue are examples of greater focus on longer-term concerns.

However, it is not clear that the VA planning process is yet yielding the desired output either for the agency or for Congress. In this regard, I remain concerned that too little attention is being paid to the reality of the constricted level of total resources that will likely be made available for the VA at various future dates. Any process for projecting future plans which fails to take into account these very pervasive limitations on resources is, in my opinion, fundamentally flawed and ultimately doomed to futility.

Finally, with specific reference to the construction planning and committee-approval processes, I believe that our committee is receiving detailed information and participating in decisionmaking at too late a stage in the process for us to be as productively and efficiently involved as I believe we should be. By the time a major project is through the preliminary drawing phase and our approval for it is sought, a huge investment has often already been made in terms of years of planning and administrative decisionmaking, as well as in terms of the expectations that have been created in the home community and among the elected officials in that area. By then, the project is virtually a fait accompli.

Thus, I believe we need to be involved earlier, at a stage at which we can more effectively weigh the merits of the general contours of a particular project, particularly in comparison to the need for other similar projects, and influence the ultimate size of the project.

I want to add a note about the need for a replacement hospital in Baltimore.

I have for some time been convinced that a new hospital at the downtown Baltimore site—as a replacement for the Loch Raven facility—is the course the VA should be taking. As you know, last year, in our committee's construction approval resolution, we took considerable pains to develop an approach that would have permitted the VA to proceed to undertake the Baltimore project in fiscal year 1985. I regret very much that the VA has not yet agreed to this approach, but I intend to continue to pursue this matter.

In this connection, I want to note that the minority members of this committee, in their March 6 letter to the Budget Committee, recommended the use by the VA of available funds to begin immediately to revise and update the plans for the Baltimore project.

Mr. Chairman, I ask unanimous consent that there be printed at the end of my remarks a copy of a January 2 letter I sent with former Chairman Al Simpson, together with the chairman and ranking minority member of the House Committee, to VA Administrator Walters in support of the construction of a full replacement VA facility in downtown Baltimore, along with a copy of the Administrator's February 7 response.

In his response, Mr. Walters noted that a task force was evaluating the issue and was to recommend "a viable and economically realistic approach" which is to be the basis of a report that the Administrator is to submit to the Congress by April 1. I'm eagerly awaiting the VA's report on the plan for the Baltimore area and will be reviewing it carefully.

These and a host of other issues which you, Mr. Chairman, and today's witnesses have raised need to be addressed very thoughtfully and carefully, and I look forward to participating in that process.

I look forward to hearing from Senator Sarbanes. I also look forward to hearing an opening statement from Jay Rockefeller at his first hearing in this room with this committee.

Chairman MURKOWSKI. Thank you very much, Senator Cranston.

[The January 2, 1985, letter and the February 7, 1985, response thereto, and a March 6, 1985, letter of support, referred to above, follow:]

Congress of the United States
Washington, D.C. 20510

January 2, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry:

We are writing as Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs regarding the Baltimore, Maryland, Veterans' Administration Medical Center.

As you know, the House Committee authorized a $111 million replacement hospital for Baltimore in both its fiscal years 1984 and 1985 construction resolutions. In its fiscal year 1985 construction resolution, the Senate Committee approved a replacement hospital for Baltimore, although at a somewhat reduced bed size and budget ($88.8 million). Language in the joint explanatory statement accompanying the conference report (H. Report No. 98-1159) on H. J. Res. 648, making continuing appropriations for fiscal year 1985, directed the VA to consider construction of a replacement hospital for the Loch Raven facility as part of its Baltimore area planning, for which $2 million was appropriated for fiscal year 1985.

In 1976, the VA completed plans for the construction of a replacement VA medical center in Baltimore. Since that time, the VA has reiterated numerous times the unsuitability and costliness of renovating the Loch Raven facility. On the basis of our staff investigation of this situation, we concur in that assessment entirely and were, therefore, very concerned to read your letter to The Washington Post, published on October 22, 1984, foreclosing the possibility of a replacement facility.

Accordingly, we want you to know that, in the context of Baltimore area needs, we strongly support construction of a new hospital facility on the downtown Baltimore site adjacent to the University of Maryland Medical School that the VA acquired for this purpose and believe that the new facility, when fully activated, should replace the Loch Raven facility, which should at that point be closed.

With warm regards,

Sincerely,

Sonny

G.V. (Sonny) Montgomery
Chairman

John Paul

John Paul Hammerschmidt
Ranking Minority Member

House Committee on
Veterans' Affairs

Alan K. Simpson
Chairman

Alan Cranston
Ranking Minority Member

Senate Committee on
Veterans' Affairs

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

FEB 1[illegible] RECD

FEB 7 - 1985

Honorable Alan Cranston
United States Senate
Washington, D. C. 20510

Dear Senator Cranston:

I am pleased to respond to your letter of January 2, 1985, regarding your support for constructing a new hospital on the downtown Baltimore site adjacent to the University of Maryland Medical School.

A task force is currently evaluating the Baltimore area veterans' health care construction requirements for the 1990's. Their review is considering various alternatives including modernizing the two existing facilities as well as constructing a replacement medical center and, in turn, closing one of the existing facilities.

Upon completing their review, the task force will recommend to me a viable and economically realistic approach. I will then provide a report to the House and Senate Veterans' Affairs Committees, outlining plans for veterans' health care construction requirements for the Baltimore area. This report will be provided by April 1, 1985.

A similar letter has been sent to Representative Hammerschmidt, Representative Montgomery and Senator Murkowski.

Thank you for your interest and concern.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

CHARLES McC. MATHIAS, JR.
MARYLAND

United States Senate
WASHINGTON, D.C. 20510

March 6, 1985

The Honorable Harry N. Walters
Administrator
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Mr. Walters:

We are writing to endorse the recommendation made by the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs in a letter to you dated January 2, 1985, regarding building a VA Replacement Hospital in Baltimore.

As you consider this important request, we hope that you will bear in mind that Maryland has suffered from a lack of construction improvements since 1972. The construction of a replacement hospital is urgently needed if we are to keep faith with our veterans and if we are to meet their changing medical needs.

With best wishes,

Sincerely,

Paul Sarbanes
Paul S. Sarbanes, U.S.S.

Charles McC. Mathias, Jr., U.S.S.

Marjorie S. Holt, M.C.

Parren J. Mitchell
Parren J. Mitchell, M.C.

Steny Hoyer
Steny Hoyer, M.C.

Barbara A. Mikulski
Barbara A. Mikulski, M.C.

Beverly Byron
Beverly B. Byron, M.C.

Roy Dyson
Roy Dyson, M.C.

Bentley
Helen D. Bentley, M.C.

Michael D. Barnes
Michael D. Barnes, M.C.

Chairman **Murkowski**. I would call on the senior member of the committee, Senator Strom Thurmond, President pro tempore of the U.S. Senate. We welcome you this morning, Senator Thurmond.

Senator **Thurmond**. Thank you, Mr. Chairman.

Mr. Chairman, it is a pleasure to be here this morning to receive testimony on the policies relating to the construction of Veterans' Administration medical facilities.

I want to commend you, Mr. Chairman, for recognizing the crucial role of proper construction planning in providing medical care to our Nation's veterans and for scheduling oversight hearings on this important subject. In view of the necessity of reducing the soaring Federal budget deficit, this committee faces the difficult challenge of weighing competing demands for limited resources. For this reason, proper planning and the efficient allocation of construction resources have never been more important.

Mr. Chairman, one of the pressing problems which the VA Construction Program must address is the physical condition of VA medical facilities. Of the 172 hospitals in the VA health-care system, 139 were constructed before 1955. Of these 139 facilities, 74 were constructed before 1945.

While no one will dispute that certain existing VA medical centers are in need of replacement or modernization, current budgetary constraints have imposed limitations on the replacement/modernization process.

I look forward to reviewing the testimony of the witnesses with regard to the distribution of available construction funds which will best serve those geographical areas most in need of hospital beds.

In addition to the physical condition of VA medical facilities, a sound VA construction policy should reflect other vital considerations. Clearly, extensive planning is necessary to prepare the VA health-care system for the changing needs of our aging veteran population. Moreover, the rapid advancements in medical technology, and the attendant increasing need for adaptable space, warrant close attention. Also, the development and utilization of noninstitutional forms of health care, such as outpatient facilities, must be evaluated.

Mr. Chairman, we have a distinguished list of witnesses present this morning to testify on these VA construction issues. I wish to welcome them all and to thank them for their efforts in assisting this committee as we seek to assure that our veterans receive the quality medical care which they deserve.

I would like to join you, Mr. Chairman, and Senator Cranston in welcoming our new member, Senator Rockefeller. I am very pleased to have him on the Veterans' Affairs Committee.

Now, Mr. Chairman, I have a conflict and I am going to have to leave. However, I will read the testimony carefully. I want you to know I am very interested in it.

Chairman **Murkowski**. Thank you very much, Senator Thurmond.

And I might point out for those of you who have wondered, a particular reflection on the new—I think it would be a perk, the candy that is located at the table. I do not know whether we should thank Julie Susman or Tony Principi. But those of you who have participated over in the House know that Sonny Montgomery always provides candy for the members of the committee. And I notice I have two pieces in front of me which I guess designates the chairman. I assume Senator Thurmond, Senator Cranston, and Senator Rockefeller each have one.

And I do not know whether this has anything to do with Senator Rockefeller's debut to the committee, but I would hope it would continue.

With that profound observation I will call on Senator Rockefeller for his opening statement.

Senator **Rockefeller**. Thank you, Mr. Chairman.

I am very proud to be at this, my first, meeting of the Veterans' Committee of the Senate. As has been pointed out by Senator Cranston, it is a matter of great pride to be able to follow in the tradition of Senator Jennings Randolph who was on this committee right from its inception until the time of his retirement this year.

Of particular interest to me, Mr. Chairman, is the whole question of what we are going to do for our aging veteran population. There are a lot of problems that veterans have—one that we may not be facing as we should be is the question of what we do and how we care for, consistent with our trust and our commitment to the veterans of this country, those who have reached 65 years and older?

It is a fact, for example, that in West Virginia, which is a State with a long and honored military tradition, that over the next 5 years we will have 50 percent more veterans who reach the age of 65 years and older. Now, the question is, How are we going to prepare for that? Are we going to carry out more construction and tend to the particular needs of the aging population within our veterans' community so as to be consistent with the overall purposes of our public trust to the veterans?

I have to say, Mr. Chairman, as I start out, that I feel a special obligation toward this part of the veterans' community. When I was Governor we tried to help them as much as possible. We were one of the few States that had no veterans' home. There was no place for an aged veteran to live when he developed a need for extra care.

There is such a home now. We started that. And it is run and administered by a Congressional Medal of Honor winner. But on the other hand, I noticed there are cutbacks in the West Virginia program in the Veterans' Administration fiscal year 1986 construction budget. And I have to ask myself, what are we doing with respect to the increased demand for those 65 years and older? And what are we doing with respect to the training for the type of medical care which is specific toward older veterans—veterans with unique personnel and medical needs? All of these things seem to me to be very crucial as we consider our health-care construction budget.

I look forward, Mr. Chairman, under your leadership to working to fulfill my public trust toward the honored veterans of our nation.

Thank you, sir.

Chairman **Murkowski**. Thank you very much, Senator Rockefeller.

And we have done a quick check and found that the successful line of West Virginians began with Senator Jennings Randolph in 1971 when the committee was first formed. And so you are the recipient of a charter membership. And we look forward to your continuing input on the committee and compliment you on your maiden speech before the committee this morning.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Chairman MURKOWSKI. Senator Mitchell.

Senator MITCHELL. Thank you very much, Mr. Chairman.

I join you in welcoming Senator Rockefeller to the committee and join you also in welcoming the witnesses who are to testify today on the VA's medical construction program.

This hearing and the one tomorrow on specific construction projects in the fiscal year 1986 budget will address an issue that is critical to this committee's oversight of the health-care needs of America's veterans. As all of the witnesses will attest, the VA's health-care system is large and complex, encompassing 172 medical centers, 107 nursing home care units, 16 domiciliaries, and 53 independent and satellite outpatient clinics. The task of maintaining and replacing, as necessary, parts of this system so it can provide quality health care with the most modern technologies and methodologies requires a huge investment.

In fiscal year 1986 the medical construction budget requested by the VA is about $712 million. This committee must be diligent in its oversight of this part of the VA budget so that we can be assured that the VA's planning, managing and allocating of construction funds is contributing in the most meaningful way to a plant that meets the immense challenge it faces.

In that regard, I commend the chairman for his willingness to address these issues in a comprehensive manner.

Because my schedule will not permit me to attend the full hearing today or tomorrow on the specific projects that the fiscal year 1986 construction budget includes, I want to make a few comments in support of one particular project, a $30 million clinical improvement project for the Togus, ME, Medical Center.

The Togus Medical Center, which is the only VA medical facility serving over 150,000 veterans in Maine, is a general medicine, surgical, psychiatric, and nursing home care facility located near the State capital of Augusta. The present buildings at Togus were constructed between 1930 and 1935 with the exception of some buildings which date from the mid-19th century.

The project will provide for a major renovation and expansion of the main hospital building, which I understand will be the first major expansion of space for general medicine and surgery since the building was completed in 1933. There will be numerous program improvements resulting from this construction project that will greatly improve the range of health-care services available to Maine veterans.

I was pleased to see the inclusion of this project in the VA's fiscal year 1986 construction budget and I strongly support its funding in the coming fiscal year.

Mr. Chairman, I want to apologize in advance to the witnesses for not being able to stay for the full hearing. I have a hearing in another committee on a bill which I am the author of, and I really have to be there to defend that. But I do look forward to reviewing the testimony of the witnesses. And again, I commend you for the comprehensive manner in which you are approaching these problems.

Chairman MURKOWSKI. Thank you very much, Senator Mitchell. We do understand your schedule and hope that you are successful in your defense.

Without objection, I would like to place in the record at this point a written statement by Senator Rudy Boschwitz, who is unable to be with us this morning.

[The prepared statement of Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota, follows:]

PREPARED STATEMENT OF HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Mr. Chairman, I want to commend you for your decision to hold two days of hearings on the VA's medical construction process. Having battled the process myself in the construction of the Minneapolis replacement facility, I have nothing but sympathy for others trying to understand the VA's methods.

I want to especially commend you for bringing in witnesses from the private sector and giving us the opportunity, on the record, to see how the VA's costs compare. Clearly if the VA can show it is comparable, it will make our jobs easier. But if it is true, as most of us suspect, that VA facilities cost more to build and more to run, then we will need to more creatively use our resources.

Mr. Chairman, I have been very interested in health care for the aging veteran -- where will we find the nursing home and acute care beds needed to care for our aging World War II vets; and how do we propose to pay for this care. I strongly believe that we can and will meet our commitment to these veterans. I plan to study the testimony with great care.

In addition, I find the timing of this set of hearings very helpful as I put the final touches on the veterans health care legislation I plan to introduce next week.

Chairman **Murkowski**. I would like to call on our first witness, who has been with us through our opening statements. And we appreciate that, Senator Sarbanes. We look forward to your statement. And I am sure you are going to express some views and recommendations concerning a certain situation in Baltimore.

Would you please proceed?

TESTIMONY OF HON. PAUL S. SARBANES, A U.S. SENATOR FROM THE STATE OF MARYLAND

Senator **Sarbanes**. Mr. Chairman, members of the committee, I have a prepared statement which I will submit for the record. I understand the time constraints under which the committee is working this morning and will therefore try to summarize it.

Chairman **Murkowski**. It will be put into the record as if read. Please proceed.

Senator **Sarbanes**. I appreciate that.

Mr. Chairman, I welcome this opportunity to come before the committee as you consider the VA construction program.

I wish to underscore my continuing strong support for the funding and construction of a new Veterans' Administration medical facility in Baltimore and to underline the pressing need for this facility.

I also want to express my appreciation to this committee for its consistent support of this facility in the past. We are very grateful for that. As members of the committee will recall, the need for this facility has been detailed on a number of occasions.

I was especially interested as Senator Thurmond summarized the age of Veterans' Administration medical facilities throughout the Nation, particularly those that have been built in the period since 1955. Each of our medical centers in Maryland predate this construction cycle and our most recent hospital, Loch Raven Medical Center, was built in 1952 as a tuberculosis treatment center. The aging of the Loch Raven, Perry Point, and Fort Howard Hospitals has become a major factor in the effort to provide acute primary care for our veteran population.

The proposed new medical center in Baltimore has received the endorsement of every analysis of the veteran care situation based upon its merits. From its inception, this center has been based upon a demonstrated need for acute care facilities in the Baltimore primary service area and I am certain that this hospital is the best response to those needs.

I feel it is important to note that this design is based upon criteria outlined in the National Academy of Sciences study on veterans health-care facilities. It has also been planned in cooperation with the University of Maryland Medical Center so that major savings will be realized through the shared use of equipment, staff, and services while ensuring that our veterans will have access to some of the best medical talent in the country.

The Congress has already authorized and appropriated some $11 million thus far for site acquisition, and architectural, and engineering design work. The project enjoys the very strong support of the State of Maryland, the city of Baltimore, the University of Maryland Medical Center, and the Association of Medical Colleges.

The Baltimore hospital was also recommended for funding in fiscal year 1985 in the 5-year medical facility construction needs assessment compiled by the Veterans' Administration's Department of Medicine and Surgery. Its prompt construction would correct serious existing deficiencies in the delivery of health care to hundreds of thousands of veterans in the Baltimore service area and offers the prospect of not only adequate, but innovative health care at a reasonable cost to the Government.

Mr. Chairman, I think this is a facility that has been very carefully planned and deserves to be funded. There is a great need for this hospital, and I urge the committee to continue its strong support for this project. It reflects the best prospect of medical care for our veterans, both in terms of planning, and design, and in terms of assurance of first-rate facilities at a reasonable cost.

I again thank the committee for its past support and urge you to continue on that course.

Thank you, Mr. Chairman.

Chairman **MURKOWSKI**. Thank you very much, Senator Sarbanes.

I might just share with you the dilemma that we have in looking over the budget authority of $577 million. We have three programs, including Houston, TX, Mountain Home, TN, and Philadelphia, PA. It is my understanding that while the Baltimore project has been up for consideration there simply was not enough to go around this time. On the recommendation of a number of agencies—the White House, OMB, the VA evidently—it was felt that from the standpoint of priorities, the $80 to $90 million just could not be added to it at this time.

And that being the dilemma, I wonder if you have any suggestions specifically to the harsh reality of the facts before us?

Senator **SARBANES**. Mr. Chairman, I think of the agencies you just mentioned, it is at OMB where we have encountered the problem. This facility has gotten very strong endorsements in terms of demonstrated need priorities from the VA itself, as well as from those outside bodies which have studied it. By continuing the delay of construction we are merely delaying the medical benefit while running up greater costs. We are talking about a very large service area with a demonstrated and dire need for an improvement in its facilities. Now that the foundations for construction are in place and the arrangement which I mentioned earlier between the VA and the University of Maryland Medical Center is in place, I feel we should move ahead with this innovative proposal. I think it offers veterans the prospect of first-rate care at a very reasonable cost.

Chairman **MURKOWSKI**. I have discussed this matter with staff and it appears that the only way that there could be any compromise would be at the expense of some of the other projects, the recognition being that the likelihood of further appropriations would be quite remote.

We will, with the assistance of the staff, again review the possibility of adjustments being made, but I feel quite certain it would be at some expense.

Senator **SARBANES**. Mr. Chairman, one of the conclusions that I would hope would result from the hearings you are holding today and tomorrow would be the need for the committee to press OMB on the attitude it has taken toward the veterans' medical facilities. At some point OMB will have to come to grips with the needs that exist and how we will address them, especially the need to maintain a quality VA medical system. My perception is that OMB has not been committed to that goal. One of our functions in the Congress, and hopefully one of the goals of this committee, is to press them in that direction.

Chairman MURKOWSKI. Well, I do not know who to lay the blame on. I think you would agree that we are faced with the realities associated with not being able to have it both ways. Either we are serious about reducing the rate of growth of the deficit, and that applies to all Government programs. And I think testimony will show, Senator Sarbanes, and I will see that you get a copy of that testimony, there is a lack of adequate planning to meet the growing needs of the veterans let alone the construction program, which is what we are discussing today. I think we can show that even should the Baltimore facility be funded, overall the adequacy of the VA to have adequate planning and a program designed to meet the needs as they occur is in reality very unlikely to happen.

As was pointed out by one of the other members of the committee, the likelihood of this budget deficit getting any better is extremely doubtful, and the realities of just where we begin to look for other areas of relief is the dilemma that we are facing.

I want to assure you that we will do everything possible to consider your recommendation and request for the Baltimore hospital. But I think it is relatively unlikely that we can expect to get any relief for further funding and it will undoubtedly be considering it at the expense of the other proposed projects.

Senator SARBANES. Mr. Chairman, I would hope that the committee would be able to outline a program extending beyond this year that would prioritize hospital construction projects based upon the rationale of merit. We are quite prepared to submit to any comparative analysis based upon merit. We feel the need for this hospital is clear and the response is an effective one in terms of the quality of care to be provided and the costs at which it would be made available.

Chairman MURKOWSKI. Senator Mitchell or Senator Rockefeller, do you have any questions?

Senator ROCKEFELLER. No.

Senator MITCHELL. Mr. Chairman, let me just say that I commend Senator Sarbanes for a very thoughtful and persuasive statement and assure him that the committee will carefully consider the suggestions that he has made, the demonstrated need in the light of the situation that now exists.

Senator SARBANES. Thank you, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much. We appreciate your testimony.

I would like to place at this point in the hearing record a statement by Senator Charles McC. Mathias, Jr., who is unable to be here.

[The prepared statement of Hon. Charles McC. Mathias, Jr., a U.S. Senator from the State of Maryland, follows:]

PREPARED STATEMENT OF HON. CHARLES McC. MATHIAS, A U.S. SENATOR FROM THE STATE OF MARYLAND

Mr. Chairman and my colleagues on the Committee:

I am here today to commiserate with you over the not-yet-constructed Baltimore Veterans Administration Replacement Hospital. Although the Maryland Congressional Delegation received the unanimous and bipartisan support of both the Senate and House Committees on Veterans' Affairs as recently as January of this year, there is still some doubt that this authorized facility will be built. I will be brief even though the history of this project is anything but.

As you know, the VA is currently evaluating the Baltimore area veterans' health care construction requirements for the 1990s. This report was requested by the Senate and House Veterans' Committees last year and is due April 1,1985. I am confident that you have been following the development of this report very closely. The results will take the form of a recommendation from the VA to be considered by the appropriate committees. It is my hope that the report will determine an appropriate size and scope for the project and validate the need for the construction of a replacement hospital. If the VA were given the go ahead to construct a replacement hospital in Baltimore tomorrow, I am told that the existing drawings and design could be updated in four to six months and actual construction could begin within the year.

The arguments for the construction of the new replacement hospital are still compelling; a growing veterans population, which now numbers nearly 630,000, with nearly one quarter of that number living in Baltimore City; lack of adequate construction improvements at VA facilities since 1972; lack of modern technology; over 70% of the veterans hospitalized at the Loch Raven VA Hospital have no health insurance and no hope outside the Veterans' system.

These are the same arguments used by the VA in proposing the construction of a replacement hospital in Baltimore City nearly ten years ago.

Let me call to your attention a survey made by the American Legion and sent to me February 25, 1985. It is a field report relative to the Veterans Administration Medical Center in Baltimore, better known as Loch Raven. I quote . . ."The current facility at Loch Raven is totally inadequate for the provision of quality patient care. This is no revelation. Virtually every visitor who has seen this station, and every evaluation and study conducted regarding the conditions at the station have acknowledged that something needs to be done. The hospital was not built to provide the kinds of service now mandated by its mission and by state-of-the-art medicine. The building is old and outmoded, and it is unbelievably congested . . . This report can only support and reiterate . . . the fact that the replacement hospital is needed, and needed badly."

Let me assure you that I am mindful of the fiscal constraints we face regarding new construction. But every day we delay in making a full and final decision on the medical needs of the veterans community in Maryland perpetuates inadequate health care and results in a higher price tag for the project. Last year, this committee applied its creativity and wisdom and approved an authorization resolution recommending construction of the Baltimore Veterans Administration Medical Center and the Philadelphia VAMC. Under the Committee action, the total amount of authorization for hospitals nationwide remained at the Administration's requested level. The Committee noted, "no clear priority determination nor planning criteria and goals were discernible which would explain the inclusion of the other five projects and the exclusion of Philadelphia and Baltimore projects."

Although this construction resolution was not embraced by the House and Senate Appropriations Committees, I believe that some compromise may still be be reached to accommodate the medical needs of the veterans in the State of Maryland. The Maryland Congressional Delegation stands ready to offer any assistance necessary, having recently endorsed the recommendation made by the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs in a letter to Mr. Harry Walters dated March 6, 1985. Mr. Chairman, I ask that the text of that letter be printed in the record of today's proceedings. I am certain that if we put our heads and backs into it and examine FY'85 budget authorities vs. FY'85 budget outlays a just and acceptable solution will be found.

Chairman Murkowski. We would call our next witness, Dr. Ditzler, Chief Medical Director, who will be accompanied by Dr. John Gronvall, Deputy Chief Medical Director, and Mr. Richard Falco, Acting Director, Facility Engineering Planning and Construction Office.

Gentlemen, we welcome you to the committee and look forward to your testimony. If you need a piece of candy it might be able to be arranged.

Please proceed, Doctor.

TESTIMONY OF DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, WASHINGTON, DC, ACCOMPANIED BY DR. JOHN GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR; AND RICHARD P. FALCO, ACTING DIRECTOR, FACILITY ENGINEERING PLANNING AND CONSTRUCTION OFFICE

Dr. Ditzler. Mr. Chairman, members of the committee, with your approval I will submit for the record my written presentation.

Chairman Murkowski. Your entire statement will be entered in the record.

Dr. Ditzler. Thank you, Mr. Chairman.

I am pleased to have this opportunity to discuss several issues concerning VA's health-care planning. I would point out that I, too, am a novice with respect to VA's health-care planning and construction. And so let me begin briefly by reviewing the dimensions of the VA medical care system.

The VA health-care system has been noted is the largest in the Nation with 172 facilities, 107 nursing homes, 16 domiciliaries, 226 outpatient clinics. As a part of a broader VA and a non-VA network we have affiliation agreements which exist between virtually all health-care faculties, professional schools, colleges and university health centers. In addition, our veterans are also provided contract care in non-VA hospitals and in the community nursing homes and with fee-for-service visits to non-VA physicians and dentists for outpatient treatments and the support for care in 46 State veterans' homes in 33 States.

So, therefore, in a system this large the construction program is a key focus of this committee's this week, plays a crucial part in providing new capacity where it is needed. I wish to emphasize that construction activities play an equal, if not more important, part also in keeping our hundreds of facilities operating efficiently and in renovating or replacing aging physical plants and building clinical improvements so that our patient care can be better served.

Planning in the VA begins with an identification of the special population we serve. The medical care need of the veteran population differs significantly from those of patients in the general population who seek care in the community hospitals. The VA is charged with caring for adult, mostly male, patients with multiple disabilities and problems, often of greater risk.

I also wish to emphasize that the VA must equally meet its responsibilities for medical care of the female veteran.

VA patients are older, have lower incomes, and are often more in need of highly specialized and more comprehensive care than their counterparts in the general population. And the VA inpatient care is linked with outpatient care and many specialized care modalities which provides for the veteran an integrated, comprehensive system of health-care deliveries.

It should be pointed out that both the letter and the spirit of the law dictate that the VA provide hospital services on a space available basis. This obligation is owed all eligible veterans and is particularly germane with respect to World War II veterans.

Chairman **Murkowski**. Could you elaborate on that specifically? I hate to interrupt your testimony, but I think this is a point of confusion in the minds of some, specifically when you say all are entitled to but with special emphasis on service-connected. What does that mean to you?

Dr. **Ditzler**. To me it means that by law I have a primary obligation to the service-connected veteran.

Chairman **Murkowski**. That is your first obligation?

Dr. **Ditzler**. That is my first obligation.

Chairman **Murkowski**. And if VA medical facilities are full to capacity?

Dr. **Ditzler**. There is a minimum number and mix of personnel that the system must provide in order to be a viable health-care system. Having the number and mix of personnel necessary to take care of the service-connected veteran means that beds excess to the needs of service-connected veterans are available. In order to utilize those beds most economically I am authorized to provide care on a space available basis to non-service-connected veterans.

Chairman **Murkowski**. That is your option?

Dr. **Ditzler**. Yes.

Chairman **Murkowski**. I want to go back and understand that specific point. You say the law requires you to serve veterans with emphasis on service-connected?

Dr. **Ditzler**. And on a space available basis, the non-service-connected veteran.

Chairman **Murkowski**. And secondarily then the law, in your interpretation, requires you to provide on space available basis regardless of your option to non-service-connected veterans?

Dr. **Ditzler**. Yes; that is correct. That is my understanding.

But I should add that we also provide care to former POW's, veterans exposed to agent orange or ionizing radiation, pensioners, veterans who receive aid and attendance or other housebound benefits and others who have eligibility.

Chairman **Murkowski**. Well, those are still veterans.

Dr. **Ditzler**. Yes.

Chairman **Murkowski**. Well, OK. So you would still maintain your obligation to non-service-connected?

Dr. **Ditzler**. Yes, sir.

Chairman **Murkowski**. Under the law?

Dr. **Ditzler**. That is my understanding, sir.

Chairman **Murkowski**. To the availability of your facilities?

Dr. **Ditzler**. That is correct, in addition to the availability of resources.

Chairman **Murkowski**. That would be your limitation?

Dr. **Ditzler**. That is correct.

Chairman **Murkowski**. Thank you. Please proceed. I am sorry to interrupt.

Senator **Rockefeller**. Mr. Chairman, could I ask one clarification on that?

Chairman **Murkowski**. Surely.

Senator **Rockefeller**. It was my understanding, when it comes to eligibility for VA medical care, that the disabled service-connected veteran has first claim, that then the non-disabled service-connected veteran has second claim, and finally any veteran who is 65 years or older has third claim but on a space available basis. Is that ranking of priorities incorrect?

Dr. **Ditzler**. It is not necessarily correct or incorrect with respect to the age 65. The law specifies that veterans 65 years of age or older are eligible for VA hospital or nursing home care without regard to their ability to pay. They have no specific priority, however.

Senator **Rockefeller**. So the oath is the test? That is the only requirement?

Dr. **Ditzler**. Well, they are not required to sign an oath if they are 65 or older.

Senator **Rockefeller**. Yes; OK.

Chairman **Murkowski**. I would hope in the balance of your testimony you could give your view on the dilemma that the law requires that care be provided for both service-connected and non-service-connected, and the reality that projections indicate that the system will no longer, at some point in time, be able to take care of the needs of the non-service-connected, particularly since your requirement is first based on the service-connected, and a forecast of just what the shortfall will be in that area.

Dr. **Ditzler**. I think I will put aside my comment——

Chairman **Murkowski**. No, no.

Dr. **Ditzler** [continuing]. And try to address your question, Mr. Chairman, because I think it is an important question.

As one looks at the immensity of the problem for the Veterans' Administration and tries to compare that with something that perhaps many of us are more familiar with, that is, the private sector, I think it important to note a singular difference in the way we generally operate in that we are providing care for a potential eligible veteran population of 28.5 million of which we estimate there are 12.5 million. Of those who are eligible, about 4 to 5 million different veterans actually use VA facilities in any given year. Nevertheless 28.5 million veterans are still potentially eligible and who, given a change in their financial or medical status, they all could call upon the VA for care in the future.

So problem No. 1, as we see it, is to try to anticipate, in view of an expanding population in terms of the older veteran, how many of them will choose to use the services provided for them by the Veterans' Administration.

The VA report "Caring for the Older Veteran" implied that we should anticipate an increased number of veterans in the future who may wish to receive services provided by the VA. That could be as many then as 12 to 15 million. Under that dimension we are then talking about the need to triple the size of our system.

There are many who would dispute that that will be so, but that is the magnitude of some of the extremes.

If one looks at simply replacing aging facilities, one has a magnitude of the problem simply in dollars, expenditures. It costs a lot of money to replace some of our aging facilities.

Now, in the private sector I think one needs to contrast what is going on in today's health-care delivery. Surgeons found out that they could treat a patient on an outpatient basis in a surgi-center at less cost than what the patient would be charged if they did it on an inpatient basis at a hospital. And so they have developed throughout our Nation surgi-centers.

Next in line came people who believed that they could provide care a little more efficiently as emergi-centers. So we now have all over our country various emergi-centers. And now we have large medical groups going out and buying some of the expensive things that hospitals formerly did, CT scanners, for example, and providing care.

In each of these instances the excuse has been that they could render a service at a few dollars cheaper than what was done in the hospital. The problem is we have not simply added all of this up. And when one adds it up one clearly sees increased costs on a nationwide basis.

For the VA to provide the same services in the most cost-efficient manner we have to do it essentially by congregating it around one medical center. For this reason when we are talking about costs, they have to be viewed beyond the idea that one is only building beds. Beds really is the small part of the issue.

A modern medical center today is a facility for several hundred thousand outpatient visits as well as thousands of admissions. All sorts of unique health-care programs, whether it be spinal cord injury or blind rehabilitation are included. Many of these things are never attached to private hospital centers.

In the context of providing the most cost efficient, most cost-effective care for a group of people requiring all of these services, I believe that the VA's planning for construction is a very wise program, but very complex and very expensive.

Chairman **Murkowski**. Well, if you will excuse me, I have to sign a proxy here, Doctor.

I agree with your conclusions with regard to the importance. [Pause.]

Senator **Rockefeller**. Mr. Chairman, may I ask a question, to take advantage of this pause?

Chairman **Murkowski**. Go ahead. Please go ahead.

Senator **Rockefeller**. Mention has been made of the deficit. Reducing the deficit is obviously crucial for veterans and for the entire country. But isn't it desirable, in fact, from a taxpayer's point of view as well as a veteran's point of view, particularly an aging veteran's point of view, for the aging veteran to obtain medical care in a VA hospital as opposed to getting care with the help of Medicare at a private hospital? Isn't it a fact that VA health care is less costly per unit than the care provided in private hospitals? It would seem to me, one, that that would be a great tribute to the Veterans' Administration, which you head. And, two, it would make an unassailable case to beef up the Veterans' Administration capacity to serve the aging population of veterans. Doing so appears to be in the interests of the American taxpayer because it would save him money—that taxpayer pays for the cost of Medicare basically anyway. Isn't it better to provide care in a VA hospital where the cost per unit is lower than in a private facility?

Dr. **Ditzler**. I think I would generally answer your questions and statements with yes. I would like to additionally state that I have spent most of my professional life in the private sector. I have been with the Veterans' Administration now for 10 or 12 years. I personally believe the VA to be the most cost-effective, efficient way of delivering high cost, high quality care.

Senator **Rockefeller**. So then doesn't that follow, therefore, that we should be looking for opportunities to save the taxpayer money and to serve the aging veteran better by taking advantage of every opportunity we can to expand VA hospital health-care construction?

Dr. **Ditzler**. I believe, sir, in fairness to those who speak for the private sector, there is a dispute as to the relative cost of the two systems. Usually it is an apple and orange comparison. And I think that is part of our problem, we have been unconvincing. On the other hand, the private sector will clearly point out that they already have hospitals built and they would like us to take over where they have maybe overbuilt.

I think those issues are things that get in the way of a clear understanding of the picture. I certainly subscribe to the view that the VA can provide the most cost-effective measure of care.

Chairman **Murkowski**. Let me refer to a couple of recent projections that may have a degree of accuracy and may have been considered by you. There was a GAO report 1 year ago that suggested the VA would need 36 percent more hospital beds by the year 2000. However, at the same time they concluded that with a more innovative and progressive policy within the VA the length of stay could be reduced and, theoretically, the VA could serve the same number of veterans by turning them over faster.

A Congressional Budget Office report states if the average length of stay remains the same in 1990 as it is now, the VA would need to provide about 26 more patients daily at its hospitals than in the year 1982 and it would need to increase the number of hospital beds by 18 percent. The report further states if the VA aggressively pursues policies to lower lengths of stay, past trends suggest that fewer patients would be served daily, than now and fewer beds than currently used, almost 14 percent less, would be required in 1990.

And I am told that the VA consistently uses, in its design for hospitals, a previous policy based on past historical experiences for confinement that are not necessarily paralleled by the private sector. And of course, you can, I suppose, discuss that in terms of adequacy of care. The bottom line here is to try and reflect on the future, and the future seems to indicate that we are going to have a greater need. However, we are going to be faced with monetary constraints that are dictated by our fiscal position, then one has to ask the question: In your best professional opinion, can the VA, through the internal process, get higher utilization?

Dr. DITZLER. Mr. Chairman, you have raised three interrelated complex issues in this question. First is the potential number of veterans that may seek our care, which is what inflates the magnitude of the number of beds that might be required.

The second issue is the length of stay per patient. I think in that regard that the VA in its acute medical care now is as good as the private sector.

One has to also then get into the question of how do our averages appear to be greater than what I just said, that is, for acute medicine? That is because I choose to believe that the VA is a human organization that has not allowed patients to fall through the cracks of society, as many of our private sector facilities have done.

To the degree to which the private sector resolves the issue of uncompensated care will determine in large measure the number of beds and the call made upon the Veterans' Administration. We clearly see now, as was seen on last Sunday's television, in one of our cities in this country the increased number of patient applications being made to public supported hospitals because they could no longer afford private hospitalization. We are seeing that in the VA system.

So to the extent to which the issue of uncompensated care in the private sector is not resolved, to the degree the issue regarding the States' ability to support Medicaids of varying kinds is resolved; on these depend the issue as to how many beds and how great is the need we must plan for in the future.

As we increase efficiency, and our DRG based reimbursement system is doing this for our 1985 budget, just as in the private sector in New Jersey, the VA will clearly show that we can achieve results equal to the private sector in the acute arena based on economies of scale from decreasing the length of stay.

A problem we have in the Veterans' Administration relating to DRG's are those patients for whom there is no parallel in the private sector, and that is our catastrophic illnesses, our attempts at long-term rehabilitation. These things are often not computed when comparing with the private sector.

Chairman MURKOWSKI. Well, Doctor, where do you expect the answers to come from? You and I are discussing the problem. And obviously, the wisdom of Congress is questionable in trying to forecast what ultimately is going to be adequate. And obviously, we get reports from GAO, we get reports from the VA, but they are conditioned. The purpose of this hearing, if it is going to do anything meaningful, is to try and zero in on specifics of where we are going to be. And I do not expect you to have it now, but I would feel a little better if I could get—glean your wisdom to suggest how this process might occur and when.

Dr. DITZLER. I think the most reliable data that we have suggests that we need to progress further with the construction of nursing homes, not to completely meet the need, but at least we have very good evidence that the private sector alone will not be able to provide us help.

Chairman MURKOWSKI. Is this an ongoing report? Is it charged within the responsibility of the VA? Is it going to be ready at a certain time? And will you have adequate input in it? I mean, is it something that will be a tool for this committee and the House committee to reflect on future construction needs within the VA for health care in general?

Dr. Ditzler. I think as perhaps we have testified at the budget hearings that there was in our 1986 budget as it went to OMB a request for more nursing homes than we are now asking for, also, a request for assistance in replacement of aging facilities, which was not a part of the President's budget.

I think as we are already looking toward a 1987 budget projection, we would like to insert more nursing homes, more community based attempts.

Chairman Murkowski. Well, Doctor, I wonder—I do not want to interrupt you, but the question of more, more, more, you know, is always appropriate because it covers the exposure. But it is the responsibility of Congress to address the problem. I think it has to be from the standpoint of forecast justification. And it has got to be composite.

And just because more needs were stricken by the administration's budget process does not eliminate the responsibility of Congress to address the needs. And I am wondering what process the VA has instituted to outline, specifically based on your charge and your professional reputation, to provide the best possible care for the veterans. What do you see the specific needs being? So that the Congress can relate to those with some degree of identification on a positive manner as opposed to just an open ended, well, we are going to need more, we are going to need more hospitals, we are going to need more nursing homes.

I would be very pleased to try and suggest or assist or work to encourage that this study be undertaken by an appropriate agency with the appropriate forecasting mechanism. To get an OMB statement or a VA statement obviously does not address what the systematic needs are going to be. If we are going to go through the budget process and the construction process I just think we have to have that.

Dr. Ditzler. Mr. Chairman, in all due respect, we operate our current planning under existing laws of Congress. And we are required by law to provide, as I indicated before, for the service-connected. We are providing for the pensioners and we are to provide, on a space available basis as we develop these facilities, for additional categories of veterans who have been accorded eligibility by the Congress.

To do that adequately in the planning mode raises the issues.

Chairman Murkowski. Well, you have an historical pattern to reflect on.

Dr. Ditzler. That is correct.

Chairman Murkowski. Obviously, you have never had all 28 million veterans use VA facilities.

Dr. Ditzler. That is correct.

Chairman Murkowski. And you never will. So I would think you could go back and plan on more or less of an historical use basis.

Dr. Ditzler. I believe, sir, that our planning currently is on the basis of the historical use. The problem that was presented in the report on "Care of the Older Veteran," which provided no definitive answers but a series of options, was that we expected the public in general to be discussing at least a year, or year-and-a-half, the issue of caring for the older veteran and to try and come up with the best and most reasonable recommendations. That report has been out less than a year. And I think although we clearly have ideas where we would like to go, I think the answer to your question is that even if we use historical perspective alone and assume that there will be no change in the use pattern, we still have major problems of finance relating to construction to simply replace aging facilities.

Chairman **Murkowski**. Well, I do not disagree with you by any means, Doctor. I am addressing the vehicle to get there from here. And it would seem to me that a composite, well thought out plan that addressed, (a) the age of the present facilities, which obviously at some point in time economics dictate in reality that they have to be replaced, (b) specifically the needs based on historic figures and utilization, the changing needs of veterans based on the age reality and the balance of services.

Without any specific long-term guidelines, decisions pertaining to the VA's major construction projects would be at the whim of Congress. It would seem to me that this would be an injustice to the VA. And I think, in all due respect, sir, that is part of the VA's responsibility to provide us not just with a wish list, but a list of projected needs based on general agreement within the VA and based on historical utilization. Otherwise we are going to be hopelessly deadlocked with OMB, the White House, the VA, the Committee or the House of Representatives.

The committee has been somewhat limited, but it would seem to me that this would be a prerequisite. And I would ask you within the VA if indeed you would not consider this to be an orderly and necessary part of the process of ascertaining long-term needs and replacement construction, whatever. Why is this not available?

Dr. **Ditzler**. I think we have presented our needs, on that basis sir. It is a problem that they are so expansive and so vast in the requirement of funding for them.

Chairman **Murkowski**. Well, have you presented them on a projection for the decade? Because these projects are 10-year projects—by the time you begin the land acquisition, you begin the planning, you begin the funding.

Dr. **Ditzler**. I believe for the next 4 to 5 years our projections have been very reasonable and very solid, sir.

Chairman **Murkowski**. Well, I would like to have you refer to the specific projections that you feel are adequate. What are they? How are they submitted? Are they submitted in your budget request?

Dr. **Ditzler**. Well, the request that was submitted to OMB certainly was our best estimate on the real needs for the Veterans' Administration in 1986 and, also, I believe contained the projection for 1987.

Senator **Rockefeller**. Mr. Chairman, could I buttress your point just a moment?

Chairman **Murkowski**. Sure.

Senator **Rockefeller**. With respect to the question, Dr. Ditzler, of long-term planning, I think there are a number of us who are simply not sure of the process by which the selection of one facility over another facility is made, or the process by which axing of proposals are made.

West Virginia, for example, has four, as you know, major Federal veterans' medical centers. Two of them were scheduled to have renovations and improvements this year to meet critical needs of veterans. In Beckley, funds of about $25 million for a clinical addition were expected to be available this fiscal 1986. And then, in Martinsburg, about $12 million was supposed to be available.

I have to assume both construction projects met the criteria of need set by the Veterans' Administration for further construction. And I have to assume that the Veterans' Administration proposed those projects. And I have to assume that they were blocked in the budget process by the OMB of the executive branch.

Now, in my own case I obviously want to fight in every way I can for Veterans' Administration projects in West Virginia, but how I do that or the extent to which I do that will be guided by my understanding of how it is that the VA makes suggestions for construction, and, how it is that OMB axes suggestions. Do both use common criteria? Are certain decisions arbitrary? Is OMB in communication with you? Is this axing of construction projects going to be the pattern?

Dr. DITZLER. As I indicated, I am a novice at the VA planning for construction.

Senator ROCKEFELLER. So am I, sir. But I have got to find out and find out real fast.

Dr. DITZLER. But I can tell you that reality would suggest as one views history that many times the VA has clearly supported programs that never quite made it through the actions of the Congress. I think it fair to say since the subject of Baltimore was introduced here that the VA this past year was acting under the direction of Congress with a $2.0 million appropriation to study the situation again in Baltimore. That report is due in another 2 weeks.

Clearly, we have supported in the past that there was a need for replacement or some action in Loch Raven. I do not think there is any question that we have indicated that as a problem area. But its current status is that we are looking very seriously at the question of whether it needs to be replaced or whether it needs a clinical addition or what would be the most cost-effective way of dealing with the situation in Baltimore.

So I think we have been looking at it for many years also. I think the question of how some things get prioritized is really not the fault of the VA's planning process, it is in the process then that goes on after the VA planners or the people in construction have dealt with the matter.

Senator ROCKEFELLER. See, I heard you say, and I agree with you, that VA care for the 65 and older veterans population is more cost effective and is a better deal for the American taxpayer and for veterans. Clearly, most VA care is provided in VA hospitals, many which will require further construction over the long term. And on the other hand, I think I detect a pattern on the part of David Stockman and the budget people to cut back sharply on construction and, indeed, to alter some of the criteria determining which veterans will or will not qualify for VA medical care.

And those two statements are at odds. That is why the process is very important to me.

Dr. **Ditzler**. I would submit that the various factions and sections and opinions in a Congress also change the outcome of what is recommended.

Chairman **Murkowski**. Well, Doctor, I do not think there is any question that the patterns have been grey as to who is responsible for what being where. And I am sure that much of the political reality would dictate that the former chairmen of this committee have had a voice in where hospitals go and where services go. But the reality I have before me, which I assume is your proposed plan, 1985 to 1989 5-year Medical Facility Construction Needs Assessment, has got the list of 10. But it further says this listing remained unchanged until the third 5-year medical construction plan for fiscal 1982–86 submitted in June 1981, which implies that for a portion of that time you have gone with a list of 10.

And of those 10 for the most part, half of them at least, are covered under the current 1986 program level. I am not going to pursue this point because I think I have made it. But I intend to pursue it directly through the Veterans' Administration for a refinement in three specific areas—reconstruction of existing facilities, new construction, and changing needs of the veterans—to see if we can begin to get some handle instead of having everybody from OMB to his brother-in-law and the service organizations trying to define what is going to be adequate and what is going to be inadequate.

There has got to be some guidelines. And I think to leave it just to the committee in the general form which it is without being more specific is again a disservice to the VA and you, sir, that have the responsibility of carrying it out.

Dr. **Ditzler**. If I can add, Mr. Chairman, last year the Congress directed us to develop a method of prioritization of these projects. And that report should be in your hands very, very shortly.

Chairman **Murkowski**. Thank you.

I would like to call on our esteemed most immediate past chairman, Senator Simpson. But, first I would like to note that we have a new policy that came over from Sonny Montgomery. We have candy.

Senator **Simpson**. Candy?

Chairman **Murkowski**. And that is provided by the professional staff. So if you need to keep your dentist in business, why, he will be pleased.

Senator **Simpson**. Well, I did not come here to be sweet.

Chairman **Murkowski**. Well, I am pleased to call on you, Mr. Former Chairman, and our new majority whip. Do you wield it or are you the recipient?

Senator **Simpson**. I get it wrapped around my neck more than I get to use it.

I want to thank you, Mr. Chairman. I want to greet our new member, too, from West Virginia. We have had a long, remarkable tradition of West Virginia Senators on this committee. It is very nice to see you here, Jay, taking the place of Senator Randolph who served here and, I believe, was one of the creators of the Veterans' Affairs Committee under Vance Hartke, if I recall correctly.

Is that not correct, Mr. Steinberg? I think he remembers these things back through the recesses.

But let me say that this was the most vexing thing for me when I was chairman and Jake Garn was chairman of the HUD Appropriations Committee and we used to grapple with this. We would say, "What?", "Where do you get these priorities?"

I will never forget 3 years, 4 years ago, I believe, where I said, "Well, give us the priority list." And there it was with 10 priorities.

Then a few months later we said, "Now, give us the priority list," and it had changed. We said, "Well, why did it change?" The reply was, "Well, it just did. We really do not know why it changed but it did."

It changes because you come to us—and this is no reflection on you, Doctor, you are new in the game, and I have really enjoyed very fine visits with you and I will enjoy more—it changes because you somehow come and tell us that with our wisdom we are supposed to know what to do with the VA hospital system, 172 units, 107 nursing home units.

Dr. Ditzler. 107 nursing homes.

Senator Simpson. Yes, the whole thing, and on and on it goes. To really pretend that the House and Senate committees know what the priorities of construction are is a laugh. And we all know that. So why don't we just forget that exercise.

We know that it comes from just good old hacking and clout. To pretend then after you have been hacked on that you needed this hospital in a certain location is really, you know, absurd. I have looked into it enough to see how they have been named after various chairmen back through the decades, and how some of them in certain areas of the United States are just really not used in any degree like they should be, simply because they were just erected there.

I think there is one House Member over there who has more VA employees in his district than he has registered voters. And he continues to work and labor and grunt for more and more. His sole function in life is to represent the VA in that district.

So somewhere along the line as we grapple with the tough issues of the $230 billion deficit you have just given us the painful observation that your needs are so expansive and so vast—that was your phrase—that we could hardly get a handle on it. And I believe that. They are so expansive and vast and expensive and grandiose in many ways, and somebody is doing that. We are doing it and you are doing it, or else you do not have the ability to say no, because you do not want the political hacking and clout to come raining down on you. But you have really never had that because you have a $26 to $27 billion budget. So nobody has really hacked on you too much.

So here we are now with this priority. And we will go through that again, and again, and again, and again, and again. It reduces your credibility and ours, and I would think that would be embarrassing. It is embarrassing to me to see a fine agency of Government when you ask them 1 year what their priorities are and the next year they have changed them, but they do not know why, they just changed them.

And then another thing, when I joined this committee I really was not after anything in Wyoming. After I had been here about 2 years and after I rose to my awesome powers as chairman, suddenly there were two construction projects in the mill in Cheyenne and Sheridan, the only two VA hospitals in Wyoming. And I said, "How did those get there?" Well, the guy nearly fainted when I said that. He said, "Well, oh, it is very important. It has been on the books in the planning stage for 20 years." I said, "I do not believe that at all. You just saw that Simpson was chairman of the Veterans' Affairs Committee and you decided to load him up over in his State, gratuitously." I never mentioned it once. Now that is the priority system of the VA. Isn't that a dandy. Ought to be embarrassing. Really is embarrassing.

And the Houston hospital is not a hospital, it is a Taj Mahal of medical care. Unbelievable. Bed after bed after bed.

I have been through this exercise. I thought when I got here the $15 million for the Minneapolis hospital was for the whole hospital. I thought that won't be too bad, but that was just for design and site. It went on to attain magnificent goals.

Well, I have vented myself on the issue. I certainly commend the chairman, and I can see that our good colleague Senator Rockefeller has a curious bent on this issue. That is good. You will need it all here.

We will go lumbering along on the basis, you see, driven by guilt that we do not do enough for our veterans and driven by guilt that every single veteran in America is somehow disadvantaged, which really offends me. I say this one more time as a veteran of this country. I served for 2 years, and that is more than millions of them have served I found. Some served less than a year and receive every benefit. Some never left the United States and receive every benefit a combat veteran draws. Some were never involved in any combat activity or arms or underarms or anything else and receive every benefit a combat veteran draws.

I see that I have piqued the curiosity of The American Legion. A portion of their prefiled testimony says:

> The American Legion is sick and tired of hearing these unending stories about millionaire ranchers in Wyoming, who, in droves are arriving at the VA hospital in Cheyenne in their Rolls Royces to get free care just because they happen to be veterans

Isn't that a dandy? Testy little statement there, I thought, because I was talking about beneficiary travel and that is so heavily abused. Every time we try to correct it somebody passes out in the back of the room.

That is where you are in this situation. And you, Mr. Chairman, will have to grapple through it all. And it looks like you are going to have a better time of it than I did because I am saying now what I said then. And I do get a little rambunctious in the process. But for heaven's sake, to believe that we do not take care of the veterans in this country in A-1 fashion is just a myth, total myth.

Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you, Senator Simpson. I might, I might add something but I won't.

Senator Specter has joined us. And I might indicate to you, Senator, since I have some idea of the subject which you will address, that we have had a very moving presentation from Senator Sarbanes over the status of the Baltimore facility. We have agreed to again review the figures in the 1986 request to see if any relief might be available. But it does appear that if any relief is indeed available it will be at the expense of one of the other four already partially funded projects.

So with that thought I just wanted to lay the foundation of our discussion. We are concerned with the construction needs of specific areas, but I guess the question is, at whose expense?

Please proceed, Senator Specter.

Senator **Specter**. Thank you, Mr. Chairman.

I would ask unanimous consent that the full text of my statement be included in the record.

Chairman **Murkowski**. Without objection.

Senator **Specter**. And I can summarize it in a few words. Only a few words are necessary after Senator Simpson's eloquent statement.

I do believe that the U.S. Senate ought to be televised for many reasons, but one of the reasons is to capture on film for the viewing public Senator Simpson's classic remarks, of which there will be many more now that he has attained the lofty position of assistant majority leader. From his public comments I think he plans to reintroduce the literal meaning of the word "whip," as that characterization has really fallen into disuse. But his characterizations I thought were most appropriate today.

And in his comment about Houston I think encompassed many of the considerations which have left the downgrading of the Philadelphia hospital. And I shall not burden the record today with the statistical base that I have put on the record in the past about the urgent need there, the shortage of space, shortage of nursing beds. And much is contained in my prepared statement.

And I do know, Mr. Chairman, and I appreciate your comments about this in the past, this is something we will have to wrestle with on this committee. And as Senator Simpson has analyzed it, and accurately so, the submissions which have come from OMB, VA, really do not comport to the established needs, especially with respect to the Philadelphia facility.

It is a pleasure to serve on this committee. The grave problems arise because at this moment Intelligence is meeting, as the chairman knows, being on that committee. And we are having the Attorney General on the Judiciary Committee, a very important subject matter, as Senator Simpson knows, so that I cannot stay for these full hearings. But we will give this matter, I know, the attention of the committee on the markup. And I commend you, Mr. Chairman, for convening the hearings. And I commend Senator Simpson for his eloquent characterization of the need for some justice and equity as to how we allocate these VA funds.

Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you.

Senator **Specter**. Thank you, Mr. Whip.

Senator **Simpson**. Yes. Thank you, Arlen.

Chairman **Murkowski**. Thank you, Senator Specter.

I might acknowledge that the staff does recognize the deplorable condition of the Philadelphia facility. There are $12 million proposed in the 1986 request. I do not know why they start with a parking lot. Do you?

Senator **Specter**. That is one of the many questions to which I do not know the answer, Mr. Chairman.

Chairman **Murkowski**. Well, if you can enlighten me I would appreciate knowing why we are starting there.

Senator **Specter**. Well, the priorities which this committee established last year I thought gave due importance to the Philadelphia installation. It is something that I have worked on long and hard with Senator Simpson. I think that is something we can correct when it comes to markup time.

Chairman **Murkowski**. All right. Well, if you have any higher priority to use that $12 million in the overall project than the parking lot I am sure that you will find this Chairman quite willing to accommodate you.

Senator **Specter**. Well, I will be looking for something more than that, Mr. Chairman, when we have the markup.

Chairman **Murkowski**. I am sure you will. That would be a bad place to start.

[The prepared statement of Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania, follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I commend you for convening these important hearings on the constuction program of the Veterans Administration. I would like to welcome our witnesses today and convey my thanks for the time, and effort you continue to give to veterans' causes, and for your thoughtful written testimony which was prepared for the Committee. Specifically, I welcome the members of the VA staff, Paul Egan and Robert Lyngh of the American Legion, Donald Schwab of the Veterans of Foreign Wars, David Gorman of the Disabled American Veterans, and Bob Moran representing the Paralyzed Veterans of America.

Mr. Chairman, as you know, one of the greatest needs facing our veteran population is that of securing medical care, and as the DAV states in written testimony, the delivery of service should entail a committment to modern, safe and efficient medical care facilities. To those ends, the VA must have and utilize a sound priority review process to ensure that those facilities most in need are targeted for necessary improvements.

Today, I want to once again alert this Committee to the critical situation facing the Philadelphia Medical Center and the hundreds of thousands of veterans in the Philadelphia area and beyond, who rely on this facility for a myriad of services. I was not satisfied with OMB's decision to delete funding for the Philadelphia project in its FY85 budget recommendations, and I am not happy with their underfunding of the project in the FY86 budget proposal.

I visited the Philadelphia VA Medical Center in February 1984, and made a first-hand inspection. I am aware of the dire need for the addition to the VA facility in Philadelphia. From what I observed and was told by personnel, I made the determination that the proposed addition , nursing home, parking facilty, and renovations were absolutely necessary and that funding had to be restored.

Mr. Chairman, as you know, funding was restored and the Philadelphia project received $17.7 million for FY85 for design and site preparation. However, I am not pleased that after Congress convinced the VA and OMB last year of the need for immediate action on this project, that this year's budget proposal reflects a one year delay in the major portion of this project, which, by the way, the VA had originally planned (in their FY 85-89 Medical Facility Construction Needs Assessment) to begin immediately after the site preparation stage. The FY86 budget proposal only includes the $12 million to build the much needed 240 bed nursing home, a pedestrian bridge, and some of the required parking space. The remaining $98.4 million necessary to complete the renovation and construction is planned for FY87.

Mr. Tom Williams, Director of the Medical Center, informs me that the project is on schedule, unlike the OMB/VA funding requests. On February 20, 1985, I submitted numerous written questions regarding the VA FY86 budget proposal to the VA including several that addressed the inadequate Philadelphia project funding level. In Mr. Walters' March 20, 1985 responses, when asked to explain the reason for a one fiscal year delay in funding for the Philadelphia project, he stated that "After Executive review, the monies allocated in the Replacement/Modernization catagory were insufficiant to fully fund three major projects...When funding is available for the other phases of the (Philadelphia) project in FY87, there will be minimal disruption to the overall construction schedule."

Mr. Chairman, I hope that you would agree that disruption of any length is not appropriate for the Philadelphia project and that this Committee is committed to timely completion of this important project. It is my sense that Congress must provide for this project in FY86 whatever funds can be utilized or obligated. Along these lines, I requested on February 26, 1985, the General Accounting Office to evaluate the FY 86 funding needs for this project.

When I receive this analysis and further clarification from the VA I believe it will substantiate my view that Congress should provide more than the $12 million requested in the Administration's FY86 budget proposal. At a minimum, it is my sense that an additional $10.3 million could be used in FY86 to complete the parking garage.

It is my strong belief that the budgetary process schedule or the problem of unacceptably high deficits should not hinder the progress of the Philadelphia Medical Center project any longer. The case has been made for the tremendous need for the nursing home and the renovation; that is not in question. It is only right therefore that earthwork or other activities that can be started in FY86 should be fully funded so that no further delays occur in providing decent medical care to the men and women of this region who have served our country.

Chairman MURKOWSKI. I do not know where we are in your formal testimony, Doctor, but you can continue to proceed if you are——

Dr. DITZLER. Well, I am not sure either.

Chairman MURKOWSKI. Well, you brought a message to us and we have aired it back and forth. And the question that I want to make sure is that you have delivered the full message that you had to us. I obviously do not know that. So I——

Dr. DITZLER. I think the only message I can give, Mr. Chairman, is that we have tried to be obedient to the law in every case. We have listed priorities as we saw them. Unfortunately, not everybody saw them as we saw them, but we did comply as best we could.

And as I also indicated, shortly, at the request of this Congress, you will soon have a priority listing on how one ought to select facilities.

Chairman MURKOWSKI. Well, Doctor, I have deep regard and respect to your reference to the law. On the other hand, you are an administrator, and we are the Congress capable of changing or altering those laws if they are in the best interests of the recipient.

What I would like to convey to you is my sincere concern is there a need for the law to be changed to make it more practical for you to work? I cannot understand why we cannot do a more systematic job of planning so that we do not have this wide divergence of opinion without fact.

Now, everybody is entitled to their opinions, but everybody isn't entitled to their own facts. We know how many veterans there are in this country. We can project what those needs are with a reasonable degree of accuracy on one side or the other. And I am going to direct a letter to you, sir, and others that may be appropriate, obviously Harry Walters. And it is going to request information on a definitive projection of the areas that we have addressed here with regard to existing facilities, proposed new facilities, and proposed changing needs of the veterans.

And I would expect you, with all due respect, to reflect your best professional judgment to suggest whether the law is so specific and the tasks so gigantic that you cannot possibly put it in definitive terms. Second, do we need to look at the law to make your job more responsive by clarifying where the obligation belongs, for example, with Congress, with respect to certain specifics. Because, indeed, there is a total lack of knowledge on this issue. There is a tremendous resource of opinion.

I have a question which relates to this point. You have indicated the law requires the VA to operate a minimum of 90,000 hospital and nursing home beds. In light of changing trends in health care in the United States and increased emphasis on outpatient care, do you believe that this request prevents you from using your resources to provide a sufficient amount of outpatient and noninstitutional services?

Dr. **DITZLER**. I believe the law's specificity about 90,000 beds includes not only hospital beds but also nursing home beds.

Chairman **MURKOWSKI**. That is correct.

Dr. **DITZLER**. So that to the degree that we need nursing home beds this is a partial solution to some of our nursing home beds. It is not a complete solution because many of our facilities are simply not designed to be nursing homes. But it does provide a partial solution.

Chairman **MURKOWSKI**. I know. Do you feel that this requirement prevents you from using your resources to provide the amount of outpatient and noninstitutional services that are increasing?

Dr. **DITZLER**. Only to the degree that sufficient funding is available for outpatient or inpatient care, which changes in its complexity simply by changes in medical technology. And that, therefore, becomes more costly as one deals with an aging population.

The average healthy 40-year-old does not require nearly the kinds of medical services that a sickly 65-year-old does. So that simply the occupancy of a bed or an outpatient visit per se does not describe the total dollar requirements.

Chairman **MURKOWSKI**. The question of the facility in Miles City, MT, has been before the committee before. I am told that it is operating at far less than capacity. Could the resources be better used to serve veterans elsewhere?

Dr. **DITZLER**. I will have to defer to my colleague for that because I am not that familiar with Miles City.

May I provide that for the record, sir?

Chairman **MURKOWSKI**. Do you know what the occupancy rate is?

Dr. **DITZLER**. Not at the moment. I've got construction people here.

Chairman **MURKOWSKI**. Well I would appreciate you providing that for the record.

Do you believe that there should be some established occupancy rate norm at which a hospital must operate and if rates fall below that norm should consideration be given to closing the facility?

Dr. **DITZLER**. Yes, sir.

Chairman **MURKOWSKI**. Do you feel that there is such a norm within the traditional administrative responsibilities you have?

Dr. DITZLER. If it is temporary the norm would be difficult to establish. But if it is a pretty consistent thing——

Chairman MURKOWSKI. Do you have a guideline?

Dr. DITZLER. Yes; I think there would be a guideline.

Chairman MURKOWSKI. Have we ever shut one down?

Dr. DITZLER. Well, the Congress was presented with a list of some 12, as I recall, back in 1966, and I think we eventually in 10 years closed 4.

Chairman MURKOWSKI. How long ago was that?

Dr. DITZLER. 1966.

Chairman MURKOWSKI. In your professional opinion would you, for the record, reflect on what should be done with the Miles City VA Medical Center?

Dr. DITZLER. I will be happy to.

Chairman MURKOWSKI. In other words, give us the occupancy and your recommendation on whether we could better serve veterans' needs in general by closing that one and providing additional facilities someplace else.

Dr. DITZLER. I would be happy to supply it, sir.

Chairman MURKOWSKI. And any others that you feel the occupancy rate is in question and we perhaps could do better by moving the asset around.

Dr. DITZLER. I would be happy to try that.

[Subsequently, the Veterans' Administration submitted the following information:]

The Veterans' Administration does not use the single criterion of occupancy rate to determine whether or not a hospital should be closed. Many variables, such as veterans' access to health care, the utilization rate of VA facilities, and the need for a VA presence in the area, are considered in determining the long-run cost-effectiveness of facilities and programs. Furthermore, many options beside closing a facility may offer better solutions for balancing medical care programs, workloads, and resources, now and in the future, and these must be examined carefully.

In this year's MEDIPP planning guidance, the VA has given special emphasis to development of actions which will enable the Agency to provide needed services within available resources. The guidance requires VA's medical districts to give priority attention to such actions, by conducting rigorous reassessments of district and facility missions, with a view to increasing the cost-effectiveness of services. Specifically, the districts are encouraged especially to consider opportunities to:

Consolidate facilities;

Increase sharing and/or contracting with cost-efficient community and other resources, where to do so would be consistent with VA quality requirements;

Eliminate non-essential services;

Increase use of ambulatory care and other alternatives to inpatient services; and

Otherwise increase efficiency and productivity.

These efforts are intended to assure that the VA will organize and allocate its facilities and other resources in a way which will provide the best possible services to veterans over the coming years. In some cases, it is possible that the termination of some programs may be necessary to make resources available for higher priorities. Any such decisions must consider a wide variety of factors in addition to current occupancy rates, workloads, and costs. They must also address demographic projections, future workloads, and potential alternatives for achieving the optimum mix, location, size and quality of services.

To assist in the reassessments of facility missions, the VA is developing a series of specific indicators to flag programs and facilities where opportunities may exist to improve the balance of services and workloads, considering the full range of options available. These indicators are being designed for use by all levels in the Department of Medicine and Surgery to identify and evaluate opportunities and recommendations for such improvements during the planning process starting this year.

Indicators under staff consideration at this stage relate to occupancy rates, as well as demographic and workload projections, costs per unit of workload, case mix trends, facility condition and the geographical distribution of programs. When the list of indicators is approved, we would expect the districts to propose an appropriate mission or operating change for each facility or program which exhibits a significant number of indicators, or else to present convincing justification as to why no such change is needed. These indicators will be an important factor in Regional and Central Office reviews of district plans.

This process of analysis will be applied to all of our facilities where current workloads or other factors raise questions. When those analyses are completed, the VA can make systematic recommendations about the best solutions for all such facilities.

Chairman **Murkowski**. My last question is: Do you feel that from an administrative point of view the third-party reimbursement application could functionally come into the VA system if the legal changes were made?

Dr. **Ditzler**. Yes, sir. I think it could. I believe that first of all you would have to have a position that it should be budget neutral to the VA from the point of view of the appropriations. If increasing revenues could be brought to the U.S. Treasury that would be fine. But I think it should be budget neutral as far as the Department of Medicine and Surgery's appropriation.

Chairman **Murkowski**. Why?

Dr. **Ditzler**. There are differing views as to whether there are cost savings or cost avoidance that I am really not prepared to get into now. But I think that is one of the issues.

I believe that down the road you could provide increased revenues to the U.S. Treasury, and legitimately. But whether that should be coming out of medical care appropriation budgeting or not, I have no opinion at this point in time.

Chairman **Murkowski**. What is, in your opinion, the justice for the current prohibition that would suggest that a veteran is employed by a construction firm—that construction firm has health, accident, and general coverage—the veteran employee as well as the employer is paying for a part of that but because the veteran is provided by law with the right and entitlement to use a veterans' hospital that the insurance policies prohibit reimbursement for that? Isn't that in effect something that the veteran is paying for already and the employer is paying for and he should have the right to utilize that if he sees fit?

Dr. **Ditzler**. That is my personal view, yes. I also pay health insurance, $3,000 a year to a private company. And they would not pay if I were in a VA hospital. Now, on the other hand, that relates to the fact that I make enough money that by most standards I should not be coming to the VA as current priority systems describe it. But nonetheless, I think it is inappropriate that most third-party carriers do not pay on behalf of the individual who receives health care in a Federal facility.

On the other hand, the Government has promised allocations of funds in the VA for the service-connected. So I think a description delineation can be made that if the veteran is service-connected then we should not be billing third-party carriers. That is an obligation the U.S. Government has already promised him. But for the non-service-connected veteran who, on a space available basis, uses our facility I see no reason why the third party should not reimburse the Government.

Chairman MURKOWSKI. And you feel from an administrative point of view with the data processing capabilities it is not an unreasonable administrative burden.

Dr. DITZLER. It would be unreasonable unless it was viewed as requiring a startup cost and then became budget neutral. I believe the projections on startup costs and the eventual yearly production of income to the U.S. Treasury far exceeds the costs.

Chairman MURKOWSKI. Well, in my letter I am going to ask you for a little more enlightenment on your views of how you feel the third-party reimbursement might administratively be funneled into your normal administrative function. My rationale, very frankly, is that with the realities of the budgetary process and the growing deficit, responsibility dictates that we look to alternative potential sources of revenue. For example, you suggested certain measures which are off-budget, but still the savings achieved could be held in the Treasury in some kind of reserve. That way when we deal with the budgetary process, we could say at least this program is making a positive contribution to the Treasury's revenues. The funds could be earmarked in the Treasury for all kinds of programs that are needed, particularly construction programs.

I can foresee the generation of those funds that come in from third-party reimbursements being put into a reserve building fund or a reserve replacement fund. Those funds would positively address how we are going to fund the replacement or the new facilities that are needed and, at the same time have a way to retire the indebtedness incurred, by utilizing this reserve for construction. And it is something that I think it is mandatory that this committee pursue and that the various veterans' organizations reflect on. Because there is no magic, nor is there much blood in the turnip. And if we are going to fund these increased needs we are going to have to find some innovative ways to do it other than just expect Congress to continue to fund it.

I appreciate the fact that you have gone into some areas outside of your proposed testimony, but it has been very beneficial, Doctor. I have no further questions other than to thank you and assure you that we are on the same track. We are trying to look toward how to provide for the expanding needs of veterans with the existing dollars and perhaps create some new ones.

Dr. DITZLER. Thank you, Mr. Chairman.

Chairman MURKOWSKI. Do you have anything further?

Dr. DITZLER. No, sir; it has been a pleasure to be here.

Chairman MURKOWSKI. I appreciate you and your colleagues addressing us this morning. Thank you.

[The prepared statement of Dr. John W. Ditzler, chief medical director, Department of Medicine and Surgery, and the Veterans' Administration's responses to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, and Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota, follow:]

PREPARED STATEMENT OF DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee

I am pleased to have the opportunity to discuss issues concerning VA's health care planning.

THE VA SYSTEM: AN OVERVIEW

I'd like to begin by reviewing with you the dimensions of the VA medical care system. The VA operates a comprehensive array of programs, including: acute medical, surgical and psychiatric, inpatient and outpatient care; extended hospital, nursing home and domiciliary care; non-institutional extended care; and a range of special programs and professional services for elderly veterans in both inpatient and outpatient settings.

The VA health care system is the largest in the nation, with 172 hospitals, 105 nursing home units, 16 domiciliaries, and 226 outpatient clinics. Veterans are also provided contract care in non-VA hospitals and in community nursing homes, with fee-for-service visits to non-VA physicians and dentists for outpatient treatment, and with support for care in 46 State Veterans Homes and 3 annexes in 33 states. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA health care facilities and nearly 1,000 medical, dental, and associated health professional schools, colleges, and university health centers. This affiliation program with academic medical centers results in about 100,000 health professions students receiving education and training at VAMCs each year. We estimate that a third of the nation's doctors have received some of their training in the VA.

Planning and operating this far-flung organization is a complex task. Not only do we endeavor to deliver services each year to millions of patients, but we work hard continually to update our programs and services to assure that the American veterans who turn to us will receive the highest quality of care available.

In a system this large, the construction program--a key focus of the Committee's hearing this week--plays a crucial part in providing new capacity where it is needed. I want to emphasize that construction plays an equally, if not more, important part in keeping our hundreds of facilities in efficient operating condition, renovating or replacing aging physical plant, and building clinical improvements so our patients can be better cared for.

We are proud of the quality of care our system provides, and also of our record of efficiency in controlling the growth of costs while continuing to meet a growing demand for our services.

THE SPECIAL HEALTH CARE ROLE OF THE VETERANS ADMINISTRATION

Planning in the VA begins with an identification of the special population we serve. The medical care needs of the veteran population differ significantly from those of patients in the general population who seek care in the community sector. There are no children and relatively few women among the veteran population. Therefore, the VA is charged with caring for adult, mostly male, patients with multiple disabilities and problems. On this point, I wish to emphasize that the VA equally meets the medical care needs of female veterans, and takes its responsibility to do so very seriously.

The manner of delivering inpatient care for the typical veteran patient differs from health care delivery in the community sector. In the private hospital, the typical patient receives medical care preceding the hospital episode and is then sent to the hospital for treatment of a specific condition. Upon completion of treatment for that condition, the patient typically returns to home, family and job with the necessary follow-up medical care being rendered in the community doctor's office.

The majority of VA patients do not follow these steps. Often, they arrive at VAMC's as self referrals. Their diagnoses and inpatient treatment proceed, usually for several medical problems. When specific treatment is completed, the need for post-hospital care must be addressed. An additional few days of hospitalization may be considered preferable to having a patient, who lives 50-100 miles from the hospital, return twice for follow-up care in the next three days (e.g., to have sutures removed or to check response to a new treatment).

The aged, disabled or chronically ill patient, who lacks a viable alternative to hospital care, presents a different problem of care for the VA than that typically faced by the acute-care private hospital. In the private sector, discharge from hospitalization tends to take precedence over the availability, suitability and economic impact of the discharge on the patient and his family. In the VA, the patient lacking alternatives may be held in chronic care or extended care wards until an appropriate placement - in a VAMC or other location, at VA expense - can be identified.

In summary, the unique medical care needs of the veteran population served by the VA, and the associated health care delivery mechanism required to meet these needs, complicate most comparisons of the VA health care system with the private sector. VA patients are older, have lower incomes and are more often in need of highly specialized and more comprehensive care than their counterparts in the general patient population. In the VA, inpatient health care is linked with outpatient care and specialized care modalities to provide an integrated, comprehensive system of health care delivery for eligible veteran beneficiaries.

It should also be pointed out that the law dictates that the VA provide hospital services for eligible nonservice-connected as well as service-connected veterans. This obligation is owed all eligible veterans, and is particularly germane with respect to World War II veterans who are now aging and whose medical needs (both acute and chronic) are rapidly increasing. These older veterans (like other older citizens) need hospitalization more frequently and take longer to recover than those who are younger. Consequently, the demands on our hospital system are projected to increase rather than diminish over the next several decades.

To assure that these demands by non-service connected veterans are addressed on the basis of need rather than age, and to assure as a matter of fairness that all non-service connected veterans are treated equally, we will, as you are aware, be submitting legislation to modify the current medical care eligibility provisions of title 38. The specific provisions of that proposal will, of course, be addressed in a forthcoming hearing and I will, therefore, not spell them out here.

THE CHALLENGE OF THE OLDER VETERAN

We have frequently emphasized that the aging of the veteran population represents for the VA an unprecedented planning challenge. This challenge stems from the enormous growth in the number of elderly veterans who will be eligible for our care. In practical terms, the challenge lies not only in the larger projections of service requirements, but in the need to give increased attention to extended care programs geared to older patients, without neglecting our acute care capability, which will continue to be needed for older and younger patients alike.

In brief, the VA is dealing with a beneficiary population whose average age is increasing much faster than that of the general population. In 1980, the proportion of veterans 65 and over was approximately the same as that of the population in general. By 1990, it will double the general population rate, and by 2000, nearly triple that rate.

In 1980, there were 3 million veterans 65 and over. Their number will surpass 7 million in 1990, and will peak at 9 million in the year 2000. Of special importance is the increase of the so-called "frail elderly", those 75 and older, in whom the incidence of both acute and chronic disease is significantly higher than in any other age group. These oldest veterans will increase more than fourfold between 1980 and 2000, from 3 percent of veterans to over 16 percent. During that period, their number will go from less than one million to nearly four million.

This demographic challenge and its implications for VA medical care are documented in the VA's so-called "aging report," Caring for the Older Veteran, published in July 1984. The assumptions in this report and the options it describes require thorough examination and debate among the branches of government, veterans organizations and the health care industry. Hence, we have suggested a dialogue on the options available. We view hearings such as this as pertinent to that process. Once a broad consensus is reached, decisions can be made as to the budgets and programs that can best respond to the population changes we have identified.

Meanwhile, as the broader policy questions are under consideration, we are moving ahead vigorously to orient our programs and staffs to meet the "geriatric imperative." We have made important progress since the aging report was written. Through our MEDIPP planning system, we continue to look ahead, as our Medical Districts assess the program needs at the local level, and identify detailed actions to meet those needs, many of which arise from the aging trend. Some highlights of pertinent actions we plan to take this year (1985) are as follows:

1. Many VA facilities are developing special programs related to medical, psychiatric and rehabilitative care needs of the "frail" elderly.

2. Advanced diagnostic techniques are being incorporated into our medical practice to improve assessment and care planning for elderly patients with acute and chronic health problems.

3. To meet the projected increases in long term care patients, especially those requiring nursing home care, we are expanding several programs:

- Six Hospital Based Home Care (HBHC) programs will be initiated, for a VA total of 49.

- Five additional Adult Day Health Centers (ADHC) will be in operation by the end of 1985, for a total of 9.

- Eleven new VA Nursing Home Care units are being added to make a total of 116.

- Two more Geriatric Research, Evaluation and Clinical Centers (GRECCs) will reach full activation. The total will be 10.

- A number of State Home Care construction and renovation projects will be continuing as well as new ones initiated.

4. A national training conference will be held this May to focus on methods and strategies for expanding VA and community joint efforts in the development, coordination and integration of services for elderly, "at-risk" veterans.

5. The VA's gerontology research and training programs will continue to prepare physicians and other health workers to deal with the problems of aging.

6. Biomedical research related to aging will be conducted in the Geriatric Research, Education, and Clinical Centers. One medical center is being designated as an Alzheimer's Disease Research Center. Other research activities will address such subjects as: biological processes of aging, treatments for Alzheimer's Disease, and prevalence of eye disorders among elderly veterans.

VA'S INTERACTION WITH OTHER HEALTH CARE PROVIDERS

The VA is an active member of the nation's health care community, and maintains many useful relationships with providers, both public and private. Community programs and facilities are vitally important to VA's service delivery, and we also systematically involve them in our planning efforts. We also contribute leadership in finding and sharing answers to problems in health care delivery through our extensive research programs and by initiating valuable conferences and other forums for such subjects as care for the elderly. I have mentioned our extensive involvement in the nation's health care education system.

As I indicated earlier, the VA is also an important purchaser of care from other providers, when eligible patients are too distant from our facilities, when special services are required, or to supplement the VA's own capacity. In fact our own general planning guidelines call for us to obtain between 65% and 80% of our nursing home beds from community or State nursing homes. In 1984, we contracted for an average nursing home care census of nearly 11,000, and partially supported 11,900 in State NHC and domiciliary beds. Also in 1984, the VA paid for more than 61 thousand episodes of hospital care and nearly 1.7 million outpatient visits in the private sector.

We cooperate closely at the local level with a wide range of providers of health and social services, especially including noninstitutional extended care, in assuring that veteran patients will be well cared for after treatment in the VA. As an example, the VA placed nearly 12,000 veterans in over 3,000 community residential care homes during 1984.

Our MEDIPP planning process formally takes non-VA health care providers into consideration in a number of ways. For example, the domiciliary and nursing home care needs assessment methodologies used by VA's medical districts to project the needs of veterans are based on the premise that State and, in the case of nursing home care, community resources will be used to augment VA resources for these services. In areas where VA services are not readily accessible to eligible veterans, such programs as fee-basis outpatient care and contract hospitalization are considered in planning for the needs of veterans. Also, non-VA health care providers are taken into consideration in planning for scarce medical equipment and special medical programs; e.g. CAT scanners, organ transplantation, etc. Extensive community involvement with our district planning boards is required by the MEDIPP process, and this facilitates our awareness at all levels of community resources, needs and concerns, including those of other providers.

THE VA HEALTH CARE MISSION

VA's health care mission essentially is to insure that quality medical care is provided on a timely basis to eligible veterans. This broadly stated mission involves the operation of an independent and comprehensive medical care system. It will require that the VA continue to provide for the special needs of veterans with unique problems, and to address the health care needs of increasing numbers of aging veterans within the limits of available resources. The VA's mission also requires support of education and research programs as part of the Agency's comprehensive medical system. Finally the VA is charged with maintaining a contingency hospital system to supplement DOD facilities and to support the National Disaster Medical System, in the event of war or national emergency.

In summary, the VA represents a large, vital, and successful national health care resource. It operates a comprehensive system of care geared to the millions of American veterans who have earned the right to the care they receive. Many of those we serve have special requirements due to the nature of their disability or chronic illness. The economic status of many veterans makes VA their only practical alternative. The veteran population is coming to need far more care as it ages, and the VA is responding vigorously to that need. Nevertheless, a broad consensus is necessary to determine how the nation will meet the peak levels of demand which will materialize in the 1990s. The VA is extensively involved with the rest of the health care community in education, in planning our programs and in a major way by purchasing services to supplement our own capacity. The core of our mission, however, is to operate and maintain our comprehensive system of programs dedicated to providing veterans with the highest quality of care available.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the committee may have.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. On pages 7 and 8 of your statement, you discuss the VA's report "Caring for the Older Veteran" and note that the options described in the report "require thorough examination and debate" so as to achieve a broad consensus". Aside from today's hearings, what steps is the VA taking to achieve such a "broad consensus" and how do you evaluate the success of those efforts thus far?

Answer 1. We have taken a number of steps to establish a dialogue among all interested parties for reaching a broad consensus on the issues involved in planning for the care of older veterans. Among them are:

1. The VA has distributed widely the document, "Caring for the Older Veteran," to professionals in community agencies, to veteran service organizations, governmental bodies and to others concerned with the aging veterans' needs for services.

2. A Special Medical Advisory Group (SMAG) Subcommittee on Aging was appointed by the Administrator in September 1984 to review the report and to make recommendations for further action. SMAG consists of representation from the non-VA medical community,and can play a useful role in incorporating the private sector's point of view into the Agency's deliberations about the care of older veterans.

3. The Geriatrics and Gerontology Advisory Committee (GGAC) of the Veterans Administration was also asked by the Administrator to review the report and make comments and suggestions. This Committee, which is made up of recognized experts in the fields of Aging and Geriatrics, has already identified many questions and issues that need to be addressed before a comprehensive plan can be developed. A series of periodic "Impact Statements" regarding the aging issue was suggested by the Committee as one means of providing useful interim decision-making information while long range options are being worked out.

4. A national training conference for health care professionals, presented by VA Social Work Service, is being held this May to focus on methods and strategies for expanding VA and community joint efforts in the development, coordination and integration of services for elderly, "at risk" veterans.

5. This year the VA is conducting a Rural Health Study to assess the distribution of need for services in rural as well as urban areas. An important feature of the study is a breakdown of service needs by age group which will provide more useful information about our older veterans. Many constituents concerned with rural health have been

contacted, informed of the VA's concerns, and are taking an active part in the design of the study. Their active involvement in the study will contribute to the development of useful options and strategies.

6. Through the VA's ongoing MEDIPP planning system, the VA's constituency awareness policy is being stressed as staff within the Medical Districts assess program needs of the older veteran at the local level, and identify actions requiring joint VA and community efforts.

The VA's future role in the health care industry, the resources available for program development, and the dynamic nature of present day health care will partially determine the final overall VA strategy. And just as a consensus is being sought in the identification of important issues and their resolution, evaluation of these efforts will also be determined through a consensus process with our constituents.

Question 2. On page 9 of your statement, you discuss plans for action in the current fiscal year relating to five programs designed to address the increasing need among veteran-patients for long-term care.

A. In your view, what would be the optimal number of Hospital-Based-Home-Care Programs?

Answer 2A. The objective in the report Caring for the Older Veteran is to: By 1990, increase the number of VA Hospital Based Home Care Programs serving veterans from 30 in 1983 to 76, and by

2000 to 98. (13 new programs were established in 1984 and 6 more were established in 1985 for a current total of 49.)

Question 2B(1). Will all of the nine Adult Day Health Centers which are projected to be in operation by the end of 1985 be located within VA facilities?

Answer 2B(1). Yes, all will be located within VA facilities. The four Adult Day Health Care (ADHC) Programs established before the creation of standards implementing the intent of P.L. 98-160 are located within VA Medical Centers American Lake, Washington; Butler, Pennsylvania; North Chicago, Illinois; and Palo Alto, California. Five more will be operating by the end of 1985 set up under the provisions of P.L. 98-160. These will be located within VA Medical Centers Brooklyn, New York; Little Rock, Arkansas; Miami, Florida; Minneapolis, Minnesota; and Portland, Oregon.

Question 2B(2). [If yes] How many VA medical centers are placing veteran patients in community based ADHCs?

Answer 2B(2). Although P.L. 98-160 authorizes the VA to contract with community based ADHCs, no contracts have been executed pending development of implementing regulations currently in process,

Question 2C. For the record, please submit information as to the Agency's plans in Fiscal Year 1986 for each of the five programs.

Answer 2C. Hospital Based Home Care:

Resources are requested in the 1986 budget for the second year activation of the 6 new programs established in FY 1985. VA will be operating 49 programs.

Adult Day Health Care:

VA will continue to operate 9 programs.

VA Nursing Home Care:

Eleven new VA Nursing Home Care Units are planned to be activated in 1986. VA will be operating 116 units by the end of the year.

Geriatric Research, Education, and Clinical Centers:

Ten GRECCs will be functioning.

Grants for Construction of State Extended Care Facilities:

Approximately $25 million is expected to be obligated for 13 projects with an appropriation of $22 million.

Question 3.

A. Which V.A. medical center is being designated as an Alzheimer's Disease Research Center?

B. What are the practical implications of this designation? For example, will special funding be provided to spur Alzheimer's research?

C. Do you anticipate designating other V.A. medical centers as Alzheimer's Disease Research Centers?

Answers 3A, 3B, & 3C. Medical Research Service has not planned to pursue designation of a center for Alzheimer's disease in the FY 1986 budget year.

As additional information, the National Institute on Aging has awarded a grant to a medical school affiliated with the Bronx VA Medical Center to establish an Alzheimer's research center. The work on the grant will be conducted at the Bronx VA Medical Center.

Question 4. On page 11 of your statement, you note that, in the MEDIPP Planning Process, the nursing home care needs assessment methodology is based on the premise that "Community Resources will be used to augment V.A. Resources" for nursing home care.

A. To what extent are such community resources factored into the needs assessment?

B. How is the availability in future years of such community resources determined and reviewed for updating?

Answers 4A and 4B. The nursing home care needs assessment is based entirely on the community nursing home experience as shown in National Nursing Home Surveys conducted by the National Center for Health Statistics. The VA assumes that veterans will require nursing home care at a rate similar to all male civilians. Given this assumption, therefore, the VA establishes utilization rates based on the data from the National Surveys and applies these utilization rates to veteran population data to project veteran demand for nursing home care.

The VA makes estimates of future need for community nursing home care beds primarily by assessing the impact of three key factors: (1) the increase in the number of veterans age 65 and over; (2) current community nursing home occupancy rates; and (3) estimates by State and local authorities regarding potential, future supply of community nursing home beds.

The VA determines a baseline need for community nursing home beds by first estimating future need based on a planning assumption that VA facilities should maintain at least their current percent of market penetration into the future. For example, if current experience is 100 veterans in community nursing home beds and if the number of veterans age 65 and over is expected to double by the year 2000, then the future need for community nursing home beds will be 200. Once the aging factor is assessed, VA planners then assess the impact of current occupancy rates and estimates of future supply on this baseline need. For example, if current occupancy rates are extremely high and if estimations of future supply include a moratorium on future growth through restrictions on Certificates of Need, then the VA planners could be expected to reduce the baseline need accordingly.

Other factors considered in the needs assessment include geographic dispersion of community nursing home beds and local conditions such as compliance with VA criteria and willingness to accept veterans under the conditions of a VA contract.

The impact of this approach to planning for community nursing home care beds can be seen in a comparison of current use of community beds with that projected in the most recent MEDIPP submission. Currently, of the veterans cared for by the VA, 39 percent are in community nursing homes. The most recent MEDIPP submission calls for this rate to increase to 42 percent by the year 2000.

Question 5. On page 12 of your statement, you note that "non-VA Health Care providers are taken into consideration in planning for scarce medical equipment and special medical programs." How exactly are such resources considered?

For the record, please provide instances of V.A. decisions not to acquire certain specialized equipment and programs and to rely instead on what is available in the community. Please include examples regarding major construction projects, such as the Minneapolis and Houston projects.

Answer 5. The Medical District Initiated Program Planning (MEDIPP) process, the V.A.'s decentralized planning process, includes collaboration with the non-V.A. health care sector as part of its approach to assessing veteran health care needs of a community and determining the best way of meeting those needs. Appropriate resource requirements for specialized programs and equipment are identified and justified at the local level, reviewed for conformance to national strategies, and found either to be justified or not.

This type of "grass-roots" planning is conducted whether it results in identification of no longer needed programs, the need to place a new program at an existing facility or to establish a new V.A. hospital in an area.

Following this review and approval, the decision to purchase the resource from a non-V.A. provider, be it equipment or service, is made by the VAMC Director. If it is a decision to purchase and reimbursement is desired from Central Office (CO), a request is submitted to CO for approval. Recent examples include the provision of manpower by the North Chicago VAMC to the Great Lakes Naval Facility for operating a CT Scanner located at the Naval Hospital. Another is the agreement reached between the VAMC Houston and Methodist Hospital permitting the V.A. to use a lithotriptor for treatment of gall stones located at the Methodist Hospital. The VAMC Houston replacement is a 1986 major construction project.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Question 1. What percentage of the VA's nursing home care is now provided on a contract basis in community facilities? And, what are the VA's projections for this type of use over the next 5 to 10 years?

Answer 1. In FY 1984, 39 percent of all VA nursing home care was provided through the Community Nursing Home Program. Our projections indicate that this percentage is expected to increase to 40 percent in 1990 and to 41 percent in 1995.

Question 2. Dr. Gronvall stated that the VA's policy does allow for the acquisition by the VA of private nursing homes. Why has the VA not taken this step? And are there any current plans to do so? If so, where?

Answer 2. The VA has not taken steps to acquire private nursing homes to serve as the equivalent of VA operated nursing homes because ready access to the medical support of hospital clinical services is essential to provision of the intensive and comprehensive level of care required in this program. Therefore, the nursing home unit must be in direct proximity to the VA medical center, and, since private nursing homes are seldom located immediately adjacent to VA medical centers, this has not thus far been a viable alternative to the establishment of VA nursing care facilities.

The VA has not taken steps to acquire private nursing homes for the community nursing home program since it already contracts with over 3,000 private nursing homes for the provision of care to veterans on an as-needed basis. Were the agency to acquire entire facilities for this program, the number of available facilities would be sharply reduced as would be the options for the veterans to be placed in facilities close to home and family.

The VA would be prepared to consider viable proposals for the acquisition of private nursing homes if, in doing so, the respective missions of the VA and community nursing home programs could be maintained.

Question 3. If the VA were to aggressively pursue the option of acquiring existing facilities -- hospitals or nursing homes -- which areas of the country currently on the replacement list could use this option? And have you contacted local officials as a first step to explore this option?

Answer 3. It is impossible to predict, at the current time, which areas of the country could benefit most from acquisition of existing facilities. In those areas where expansion of VA capabilities are warranted due to projected increases in the veteran population, concurrent growth in the general population may well result in minimal opportunities for acquisition of existing facilities. For those areas where adequate numbers of VA facilities do not exist to meet current and projected demands for health care, opportunities may exist to acquire existing health care facilities. Such cases, however, must be dealt with on a case by case basis as opportunities to do so arise. Contacts with local officials do not occur until such time as the need for new VA facilities has been determined. Such contacts normally result as a part of the site consideration/selection process.

Question 4. At the Tuesday, March 26, hearing the VA witnesses stated the VA did not want to get involved with "bailing out" the private sector by having to purchase or lease empty private hospitals. Does this accurately reflect the VA's policy -- namely that new construction is the direction to take?

Answer 4. Expansion of the VA's health care delivery system occurs only after the need for such expansion is justified through the Medical District Initiated Program Planning (MEDIPP) process. Through a rigorous needs assessment analysis and review, the unmet health care needs of veterans are identified and recommendations on how those needs can best be served are developed. Recommendations on facility sizing and general location result from consideration of such factors as the size of the veteran population to be served, access for that population to existing VA facilities, and community health care resource availability. Approval of a planning recommendation then requires that further analyses be conducted to determine whether new construction, acquisition of an existing facility, or lease of an existing facility is the most efficient, cost effective alternative of meeting the identified health care needs. As a part of the site selection process, all interested parties are afforded an opportunity to submit proposals for consideration. However, only those proposals relating to offers of land and/or facilities within the area identified as appropriate for establishment of a new VA facility receive further consideration.

Question 5. The placement of an outpatient clinic in Duluth, Minnesota is in the VA's five-year-plan scheduled I believe for funding in FY87. I believe the area's veterans and the medical community are more than ready for it this year. Please tell me why the VA did not request funding this year. And I would like to receive a commitment from you that it will be included in the FY87 request if it is not sped up and funded this year.

Answer 5. A proposal to expand the VA's health care delivery system through establishment of an outpatient clinic in the Duluth, Minnesota area has been submitted for review as a planning concept, as have numerous other new outpatient clinic proposals. No resources were requested in the FY86 Budget for this clinic since a clear decision had not been made to establish a VA outpatient clinic in the Duluth area. Currently, further analysis of system-wide priorities is being conducted to assure that budgetary resources available for outpatient programs will be utilized in the most efficient, cost effective manner possible. Please be assured that the Duluth outpatient clinic proposal will receive every consideration in our current analysis.

Chairman MURKOWSKI. Next we are going to have representatives from The American Legion, Mr. Paul Egan, deputy director, National Legislative Commission, and Mr. Robert Lyngh, National Rehabilitation director. Both will address our committee.

In the interest of time I must ask you to highlight your remarks. And your entire statement will be entered into the record. I am sure that you have run into this difficulty before. I just hope that the discussions that have taken place prior to your testimony have been somewhat meaningful to you. I believe that the views of the committee members indicate the dedication of the committee to try and reflect on the problems associated with fulfilling the needs of eligible veterans, while, at the same time, recognizing we cannot continue the tradition of going to Congress and simply asking for more money.

Please proceed.

TESTIMONY OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION

Mr. EGAN. Mr. Chairman, Bob Lyngh will summarize our statement. But we will be available then for your questions, should you have any, either in writing later or presently here.

Mr. LYNGH. Mr. Chairman——

Chairman MURKOWSKI. Mr. Lyngh.

Mr. LYNGH [continuing]. In conforming to the committee's request we are merely going to extrapolate a few remarks from our prepared statement.

Chairman MURKOWSKI. Thank you.

Mr. LYNGH. I would like to take the opportunity, if I may, to say that in the course of the previous witnesses a great many things have been said this morning in which we would like very much to have an opportunity to engage in dialog and perhaps some level of debate, which this particular hearing does not give us an opportunity to do, particularly with reference to third-party reimbursement. We would hope for an opportunity to present our views on that particularly difficult subject at some appropriate time to the committee.

Chairman MURKOWSKI. I assure you, Mr. Lyngh, that that particular subject, when and if it is considered by the committee, will be preceded with a hearing.

Mr. LYNGH. Thank you, sir.

We are pleased to appear before the committee today and have the opportunity to present our views on the present status and the future of the Veterans' Administration medical construction budget. May we say at the outset that our organization has very strong views on the subject and that these views have developed through the past several years in the main as a result of the information obtained through the several hundred site visits completed by American Legion field representatives at VA medical centers and clinics.

The site visit reports include detailed descriptions of the needs and the problems of VAMC medical staffs that have to practice modern medicine on sick and disabled veterans under less than optimum conditions primarily due to outdated and inadequate physical resources.

For fiscal year 1986 the President has proposed for medical construction for VA the amount of $712.9 million, which is a decrease of $154.9 million from fiscal year 1985. At this particular appearance we do not propose to object in detail to the administration's proposal for the budget item except to say that while we under stand the severe budget constraints under which the Congress is operating, nevertheless, we cannot say the decrease in funds to be provided to this account is a good or justifiable thing to do in view of the fact that more than almost anything else in the VA budget this is a catchup item in which the Government is now doing some of the things that should and could have been done years ago at much less cost than is now being experienced. Is this in fact yet another example of our Government being pennywise and pound foolish?

The current status of the physical plant of the Department of Medicine and Surgery is that it is a multibillion dollar capital investment of the Federal Government in health care. We all know the VA health-care system is the largest integrated, comprehensive health-care program in the United States today.

Over the many years since it was established shortly following World War I and through the years of expansion following World War II the physical plant was allowed to deteriorate even as it was being built up. The result of that anomaly is that the system today has some of the finest and most up-to-date facilities in the country, and at the same time is using facilities that predate World War II, and in isolated instances, it even continues to occupy structures that predate the 20th century.

There is another important question, which is just how large a system for veterans' health care can we reasonably expect the Congress to authorize? The American Legion has never expected, nor has it ever said, that it expected the Government to operate a system that would care for 28 million veterans. We know very well that would be impossible. We know, also, that most veterans have other options available to them besides the Veterans' Administration.

Matters have come to our attention recently through the site visits of our field representatives and reports from local Legion organizations that have highlighted for us the need for VA Central Office to do something about its entire production program, stretching all the way from identification of need to planning and actual construction once funding is provided. We are thinking of specific situations that indicate a general problem, as in the case of a clinical addition that at the point where it was turned over to VA by the contractor had more than $10 million of needed modifications before it could be used for patient care. And we are aware of another example of a hastily built, large facility that created an absolute nightmare for the staff when it began admitting patients. This particular instance is a classic example of how the Government gets a bad name as to how it spends the taxpayers' money.

It is our hope that these and some others of the failures and lapses in the VA system of identifying, planning and constructing medical facilities are being corrected. It is difficult for us to support the Veterans' Administration when it makes what can only be described as indefensible errors.

In conclusion, Mr. Chairman, we of The American Legion are aware that some of the witnesses to be heard during these hearings will define positions that are directly at odds with the positions of the Legion as we have presented them. We wish it to be known that we truly believe our positions are correct and proper given the constituency we speak for. We will continue to defend our positions. And it is our sincere hope the committee will give due consideration not only to what we say but to why we say it.

Thank you, sir.

Chairman MURKOWSKI. Thank you very much, Mr. Lyngh. I assure you that the committee will remain openminded and consider your suggestions. And I would hope that The American Legion will also remain openminded and consider the suggestions of the committee and the other witnesses as well.

Tell me, you indicated sensitivity toward the third-party reimbursements. I wonder if for the benefit of the committee you would just give us an overall concise statement as to your feeling as to the merits of it?

Mr. LYNGH. Well, I would be very happy to, sir. And I will make it as succinct as I can.

I have debated this face to face with David Stockman. And he and I are in agreement to disagree on it. But I would be very happy to tell you basically how we feel.

And that is, that should third-party reimbursement become the law of the land what essentially is going to happen is that the nature of the Veterans' Administration health-care program as we now have it will be changed from a benefit program to a copay program in which the veteran will participate in sharing the cost of his health care through his premiums to his health insurance policy. Should that happen, in our judgment the existence of the system as we have it today in the face of opposition in the private sector which is proposing such things as mainstreaming and vouchering would be almost impossible for either the veterans, organized veterans themselves, or their friends in the Congress to defend.

Because if you go to third-party reimbursement you immediately raise the question of if you can do that why not funnel the veteran patient into private sector hospitals and have the VA pay for them through a vouchering system as the Federal Government does with such programs as Medicare and Medicaid.

We believe that third-party reimbursement would probably strike a stronger blow against the health-care system that this Government has provided for its veterans since World War I than almost any other single action that could be taken with reference to that total program.

Chairman MURKOWSKI. Well, I respect your point of view. I would suggest that as you reflect on the realities associated with the problem that is before this committee. I, as chairman, just do not intend to grapple with the issue by simply treading water and taking what comes down the line from Congress or David Stockman or any other. Try and set some long-term goals of how we should get there from here. And unless we are generally collectively prepared to assume some innovative alternatives, I do not see any relief from the status quo. I think this is frustrating to the administrators, frustrating to the service organizations that have an obligation to the veterans and, certainly, frustrating to the Congress.

I do not share necessarily your conclusions. I share the concern that a mainstream application could occur if it were not curbed by law. But the reality of proposing the third-party payments for the veterans' facilities only is just what it means. It means Congress can change it and broaden it or Congress can limit it.

But the reality that I see here is that the ultimate needs surpass the goals of any organizations to necessarily maintain a status quo. If we are going to seriously come up with facilities to meet the needs of the veterans we damn well better figure out how to do it. And to just come before Congress and suggest that we get more money when the realities of the budget consists of 18 cents out of every dollar going for interest on the accumulated debt, which is not your fault and not mine and everybody's, dictates that it is either going to be turned around or we are going to get less and less and less and less every year and we are not going to meet the obligations.

Mr. LYNCH. Might I just say one thing, sir?

Chairman MURKOWSKI. Surely.

Mr. LYNCH. Without elaborating and with regard to your time, as far as we are concerned we have suggested and participated in other suggestions that are being made. And there are a number of them on the table and available for the committee's consideration certainly to maximize the cost-effectiveness of each dollar the Congress may assign or allocate to health care for veterans.

There are many things that are being done in VA that could be done even more on a more broad basis and scale that would enable the VA to take care of a great many more veterans at much less cost. Those options are available.

Mr. EGAN. Mr. Chairman, one further point——

Chairman MURKOWSKI. Mr. Egan.

Mr. EGAN [continuing]. With regard to third-party reimbursement, one further thing needs to be kept in mind. And that is, unless we are mistaking something terribly, most insurance companies require a fairly elaborate accounting system for the charges for the care of any individuals throughout a stay in the hospital. I do not know that the VA is currently equipped to account for the costs of care as generally required by insurance companies. And it may be, to put a system of accounting in place may ultimately cost more than what is collected from the third party.

Chairman MURKOWSKI. Well, it certainly may. But, you know, I have seen it work in Alaska. And we are as smart as the average bear and can figure it out. An accounting system is designed now to go on data processing and you train the people to utilize it. There is no great magic to it.

I do not believe that an efficient accounting system couldn't be developed. And I do not want to pursue it. I think that you have made your point, Mr. Lyngh and Mr. Egan, on how you feel about it.

I have checked with the staff, and they tell me of the recommendations that you have proposed on additional ways, do we have them?

Mr. LYNGH. They are in the statement and earlier statements that we have presented on the budget.

Chairman MURKOWSKI. They are in the earlier statements on the budget. OK.

Since this hearing is going to remain open, I would appreciate it if you, on behalf of The American Legion, would reinsert or circle that particular group of recommendations that you have with whatever elaboration you might care to make as to the process of initiating those changes to result in greater savings and greater services.

Mr. LYNGH. If we may, we will write you a letter on that, sir.

Chairman MURKOWSKI. You certainly may. I would look forward to it. And the sooner we get them the better, because if we want any legislative changes initiated, why, we want to do it as soon as possible. And I assure you, I would welcome those. If you do not think you have gotten my attention you had better hit me over the head with them, because that is what I have asked for and that is what I have—it has not gotten my attention until just now. That is why I wanted to make sure that I picked up on it.

And again we can reflect on your concern over the accounting, we can reflect on your concern over changing the system from the standpoint of the main——

Mr. LYNGH. Mainstreaming.

Chairman MURKOWSKI [continuing]. Mainstreaming the process.

Mr. LYNGH. If I may——

Chairman MURKOWSKI. And I know how you feel on that and I do not even want to go into that because that is not an issue now.

What is an issue is whether third-party reimbursement necessarily has to challenge that. And I think it is just a matter of how it is set out.

What galls me is the reality that the veteran in many cases is paying for health service that is withdrawn from his check, as well as his employer's, for the benefit of an insurance company that never has to meet the obligation by law. And that does not seem equitable either.

Mr. LYNGH. Well, Mr. Stockman said when we were talking to him, and I think he may have had a hold or a point there, and that is that the insurance industry has been getting a free ride on their premiums for many years by virtue of the fact that they provide no care for Federal beneficiaries. And I think that——

Chairman MURKOWSKI. I think that is wrong.

Mr. LYNGH [continuing]. That is a collateral, but it is another issue, really.

Chairman MURKOWSKI. Well, I know. But just because you are a veteran does not mean the insurance company should have a free ride on you.

Mr. LYNGH. Well, but most of the veterans that have health insurance use it in private hospitals.

Chairman MURKOWSKI. Yes.

Mr. LYNGH. That is true.

And I should add one further thing, if I may. And I do not want to take any more of the Senator's time.

Chairman MURKOWSKI. Sure. Go right ahead.

Mr. LYNGH. And that is in context with this accounting situation. There is one thing that the Veterans' Administration, Mr. Chairman, must provide that you will not find in any private sector hospital, and that is, that once the VA accepts responsibility for a patient by admitting him to its system it accepts responsibility for what is referred to as a continuum of care. In other words, it must concern itself with medical, socioeconomic responsibilities for that veteran.

There is not anybody, including all the Members of this Congress, that would agree to the Veterans' Administration turning a veteran out after they provided for his immediate necessity, if he has got pneumonia or needs to have his gall bladder taken out, 72 hours later such as in a private sector hospital discharging him if he has no place to go.

Private hospitals do not care where he goes. But the VA cannot do that. When they get him in there they have to make sure that when he goes out of that hospital he has a place to go and that somebody is going to look after his welfare once he is discharged. That is going to be a factor among all the others that are going to have to be included in any computation with reference to third-party reimbursement. Because I do not think that even the Congress would want the VA to arbitrarily divest itself of that responsibility when we contemplate the fact that most VA beneficiaries are the oldest, the sickest and the poorest among the veteran population.

Chairman MURKOWSKI. I do not disagree with that at all. But by the same token, if the veteran has the coverage and can be legitimately billed under the coverage is it not in the interest of the Government to initiate that billing process? That is the question.

Well, we will be, obviously, relating and reflecting on it. And I thank you very much for your testimony.

Mr. LYNGH. Thank you for the time, sir. We appreciate it.

Chairman MURKOWSKI. Gentlemen, we appreciate it. Thank you. I assure you your entire statement will be entered into the record.

Mr. EGAN. Thank you.

[The prepared statement of Paul S. Egan, deputy director, National Legislative Commission, and Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, The American Legion; and the Legion's letter, dated March 28, 1985, to Chairman Frank H. Murkowski, follow:]

PREPARED STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION AND ROBERT E. LYNCH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion is pleased to appear before the Committee today, and to have the opportunity to present its views on the present status and the future of the Veterans Administration Medical Construction Budget. May we say at the outset that our organization has very strong views on this subject, and that these views have developed through the past several years, in the main as the result of the information obtained through the several hundred site visits completed by American Legion Field Representatives at VA Medical Centers and Clinics. The site visit reports include detailed descriptions of the needs and the problems of VAMC medical staffs that have to practice modern medicine on sick and disabled veterans under less than optimum conditions, primarily due to outdated and inadequate physical resources.

For Fiscal Year 1986, the President has proposed for medical construction for VA, the amount of $712.9 million, which is a decrease of $154.9 million from Fiscal Year 1985. At this particular appearance we do not propose to object in detail to the Administration's proposal for this budget item, except to say that while we understand the severe budget constraints under which the Congress is operating, nevertheless we cannot say the decrease in funds to be provided to this account is a good or justifiable thing to do in view of the fact that more than almost anything else in the VA Budget, this is a catch-up item, in which the Government is now doing some of the things that should and could have been done years ago, at much less cost than is now being experienced. This is yet another example of our Government being penny-wise and pound foolish.

Any discussion of the medical construction budget, if it is presented in a detailed and comprehensive manner, would be extremely complex, both as to justification for each and every project, and the methodology by which needs are identified, as well as the complications of advance planning, site selection, costing and the development of facilities to meet the statutorily defined mission of the VA's Department of Medicine and Surgery. All of that being so, we will not attempt anything so complex and detailed, but will confine our remarks to the broad range of issues that must concern the Committee as it considers what it should recommend and support in construction funding for VA for FY 1986.

The current status of the physical plant of the Department of Medicine and Surgery is that it is a multi-billion dollar capital investment of the Federal Government in health care. We all know the VA health care system is the largest, integrated, comprehensive health care program in the U.S. today. Over the many years since it was established shortly following World War I, and through the years of expansion following WW II, the physical plant was allowed to deteriorate even as it was being built up. The result of that anomaly is that the system today has some of the finest and most up-to-date facilities in the country, and at the same time is using facilities that pre-date WW II, and in isolated instances, it even continues to occupy structures that pre-date the Twentieth Century. That seems almost impossible to believe, but it is true. A basic question could be asked of this Government, why is it treating veteran patients in structures built before 1900? And why is it treating patients, as at Tucson VAMC, in buildings constructed as a tuberculosis hospital, or, as at Buffalo, New York, in a building without air conditioning? The fact is that money spent on the physical plant of the Department of Medicine and Surgery is a capital investment by the United States in a priceless and irreplaceable national resource. For this reason, even at this difficult time for Federal expenditures, The American Legion has no difficulty in saying that money spent on VA medical construction, is not money lost. It is money converted into the physical resources of the VA health care system, and it is money well spent.

There is no doubt that at this time in 1985, the total health care system of the United States is in a state of flux. This sea change is caused by a multiplicity of factors that is much too complex to discuss here and now. In fact, we are not sure that any authority now in existence has actually pulled together the entire schematic of health care in the nation and presented it in one picture. We are not even sure it could be done if some authority were disposed to try to do so.

For our purpose today, we will mention only two of the most important factors impacting on health care - the aging population, and the escalating cost of health care for each and for all Americans.

Due to increased longevity, the American population is steadily growing older. Older people require more health care resources. And due to an unending number of factors, the cost of health care in the U.S. is rising faster than any element of the network of providers can deal with.

The fact is that Americans today enjoy the best health care in the world. It is also the most expensive health care, and up to now, no authority, including Congress, has figured out what to do about the rising costs.

Where the VA system fits into this picture is that it too is providing some of the most sophisticated medicine that can be found anywhere, and the cost of its care is also rising almost faster than Congress can provide money for it.

But - while VA health care is expensive and getting more so, there is another all-important factor that must be kept in mind whenever the VA system is discussed. That is the fact that the VA system takes care of, first those who were injured or disabled while in the active service of the Armed Forces, and second, some 3 million of the sickest and poorest of Americans. So - it is an obvious truth to say that if the VA system were suddenly removed from the network of present health care providers, the loss could not be made up by what would be left. We have absolutely no hesitation in saying that most of those for whom the VA provides care are not the clientele that is sought by the private sector, or by any other element of public sector health care delivery. In other words, the VA is relieving the nation of a health care burden it is not prepared to care for in any other way.

And in that context, we would like to make one categorical statement at this time. The American Legion is sick and tired of hearing these unending stories about millionaire ranchers in Wyoming, who, in droves are arriving at the VA hospital in Cheyenne in their Rolls Royces to get free care just because they happen to be veterans. Our organization makes regular site visits to each VA Medical Center on a rotating basis, and we have volunteers and American Legion Service Officers working regularly in every hospital and clinic. We believe we know more about who uses the VA system than anybody else, other than the VA itself. And we know that the VA system is populated by veterans who are overwhelmingly the oldest, the sickest, and the poorest of their number. They are cases who, for the most part, nobody else wants to be responsible for, and if they did not have the VA system available, large numbers of them would go without any care at all - and thus would die sooner than they are dying now.

We have asked the VA for an updated profile of the present patient population, and we are waiting anxiously to receive it. We believe it will show the statements we are making here are true.

The VA's health care mission is statutorily defined, and it is fourfold:

1. To provide medical care for sick and disabled veterans to the extent of its capacity.

2. To provide health manpower training for the nation.

3. To engage in both basic and applied medical research.

4. To act as the principal contingency back-up to the military medical system in case of an outbreak of hostilities overseas involving U.S. Armed Forces.

No one can, or ever has fulfilled those missions as well as the VA is doing today. Nor is there any other system now in existence that could do so.

Let us for a moment address the question that has been raised in some quarters, including among some within the veteran community, as to whether the four stated missions of the VA are justified, or whether they should be changed or reduced.

Apparently no one questions the obligation of the nation to care for the service disabled. The question has been raised, however, as to whether service connection should extend beyond the combat injured. That is a false proposition. The fact is that soldiers do as they are ordered and accept the consequences. Some sweep the barracks and some engage the enemy in hand to hand combat. Soldiers don't control that. Also, some have more combat than others - and some combat is more fierce than others. Who is to judge this? A soldier who is shot, or the one who is hit by a truck on the company street are both doing as ordered. And as to disease, as against job related injuries, it is a fact that a soldier is on duty twenty-four hours a day all the while he or she is on active service. No one can say for sure what traumatic injuries, or environmental or stressful circumstances may affect the service of the individual. For the reason of all these indeterminables, it has always been the position of The American Legion that the sole, equitable criterion as a qualifier for care is that the soldier carries out the orders given by competent authority in an honest and faithful manner.

As to care for the nonservice-connected, that benefit was granted by the American people, through the Congress, for two fundamental reasons. First, in order to provide the quality of care required for the service disabled, it is necessary to develop a mix of patients that will retain in VA service the quality of health care professionals needed to provide the care. And second, the American people have expressed the desire - ever since the end of the first World War, that the poorest among the veteran population should be cared for by VA as against relegating them to the mercy of public sector facilities. This is a benefit - pure and simple, and it is a benefit the people have shown a willingness to pay for in recognition of the willingness of those among them who were prepared to take up arms to defend the national interest.

As to the proposition that veterans be cared for in the private sector through some kind of vouchering system, we will deal with that summarily by stating that The American Legion does not consider it acceptable that the care of veterans be turned over to those who have no interest, concern or dedication to caring for those who have served. The hazards of poor quality care engendered by the indifference of those who are motivated solely by the profit incentive are not what we want for veterans. As to the cost-effectiveness - arguments on that subject sound strange coming from that sector of the national economy that is more out of control as to cost increases than any other.

Having proceeded to this point, we now address a more important question. Which is - just how large a system for veterans health care can we reasonably expect the Congress to authorize. Let us say at the outset of attempting to answer that question, that The American Legion has never expected, nor ever said it expected the Government to operate a system that would care for 28 million veterans. We know very well that would be impossible. We know also that most veterans have other options available to them beside the VA.

Most veterans, as most Americans, during their working years buy and maintain health insurance - and use it when they need it. That is attested by the fact that not more than about 10% of the veteran population ever uses the VA system. Older veterans for the most part have Medicare, and many of them supplement that with additional purchased health insurance. Also, most veterans, when they are ill, prefer to use facilities as close as possible to their residence, in order to be near their families. So those who tend to use the VA system are for the most part, the poorest among the veteran population, and those who reside closest to the VA facilities.

It must also be expected that those most likely to use the VA are those with the most serious illnesses, mainly in the category of what are referred to as the catastrophic conditions, such as chronic heart disease, stroke, cancer, things like chronic or rheumatoid arthritis, and those systemic diseases that are the most debilitating.

The goal of The American Legion is that the VA system will be large enough and its facilities distributed in such a way that it will be readily available to those who are most likely to need its services. As a result of the way the VA system developed through the years, we cannot say all of its facilities are ideally located to reach all of those who need it the most. It is sufficiently large now, however, that it is available to most of those who need it.

There is no question that the system has many problems - funding and the needs for medical construction being among them. It is also true that the system continues to provide high quality care to very large numbers of veterans, who but for the VA, would have no place else to go.

It is also our intent to encourage both Congress and VA to foster the development and implementation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients. The trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible. This enhances both the quality of life provided the patient, and is the most cost-effective method of practicing modern medicine.

With the inevitable limitation of resources within the VA system, the question arises whether there can be measurable sharing of facilities with the Department of Defense and with hospitals and clinics in the private sector.

Of course there is some sharing presently in both categories. VA does have some sharing arrangements with military hospitals. We are under the impression, without having total information readily available that there are ongoing conversations between local VA and military institutions concerning both emergency sharing and routine sharing. We will be frank to say that in our judgment this particular matter may justify some special attention by the Committee and by VA Central Office, to make sure local hospital managers and staffs are approaching this sharing possibility in a constructive manner. We are aware there is a tendency to parochialism on the part of managers, that could in this instance inhibit a genuinely cooperative approach to the possibility of sharing arrangements that could save on staff and equipment. There are always conditions, of course, and local managers are bound to maintain focus on their defined mission. But we are not absolutely sure there could not be more sharing arrangements than are presently in place - if there is a truly cooperative and positive approach taken by responsible officers in both VA and the military services.

We believe the same line of reasoning applies to sharing between VA and private sector hospitals. There are such sharing arrangements now in place, and in many instances working very well. These involve mainly university hospitals that have affiliation with VAMCs. As to other private sector institutions, we would say that if this is not being pursued, it should be. Again, we believe more precise direction from Central Office would be needed to assure a thorough exploration of the possibilities.

The American Legion has no objection to any sharing arrangements, as long as they enhance and sustain the primary mission of the VAMC, which is in all instances the provision of care to sick and disabled veterans.

There is another feature of medical construction that calls for comment in this statement. That is the possibility of converting facilities presently configured for acute care to long-term care functions. This possibility has been pointedly raised, for one source, by the Office of Management and Budget. We will tell the Committee how The American Legion views that possibility.

We do believe there may be some instances where such conversions may be made. Before it can be done, what is required is intensive survey and study by Central Office and local managers. All such studies should be projected from the facility's primary mission and the demographics of its natural constituency. Where, for instance, the demographics of the veteran population in the primary service area (PSA) have modified to the point there is a significantly greater need for long-term care beds than for acute care beds, and where the physical structures being used are built and can be configured in a way that will provide for efficient and cost-effective utilization, accommodating chronically ill, non-ambulatory and fragile patients, then we would be supportive of the modifications. There is a danger, however, that Government officials and others who might become involved in projects of this kind will make decisions based on considerations projected from a lack of understanding of the VA's mission in health care. We have a good example of that in the case of the Grace Commission, where efficiency experts from the corporate world, having neither understanding of nor concern for the needs and welfare of veterans, as those needs are identified and accepted by both the Congress and the VA, made recommendations that would not in any way enhance the ability of the VA to fulfill its mission. We are confident the Committee will understand why the Legion's reaction to that approach was less than friendly.

Let us state for the record that The American Legion will support measures to convert present acute care beds to long-term care beds, where such change will strengthen the ability of VA to carry out its mission, and where the changes lend themselves to efficient and cost-effective operations adding to the better welfare of veteran patients. We will belabor the point just a little by saying that not every ward in an acute care facility, that is not fully needed for acute care patients, is suitable for conversion to long-term care. A ward on the top floor of a 10 story building, for example, would not in our judgment lend itself to conversion to be used by nursing home patients who are fragile and non-ambulatory. In addition to patient mobility there is the problem of what would be done in case of a fire or some other emergency requiring immediate evacuation. These things, and others, all have to be looked into very carefully before modifications can be undertaken.

And there is yet one more issue we would like to mention, even though this is a rather broad presentation on the general subject of medical construction.

Matters that have come to our attention recently, through the site visits of our Field Representatives and reports from local Legion organizations have highlighted for us the need for VA Central Office to do something about its entire construction program, stretching all the way from identification of need to planning and actual construction once funding is provided.

We are thinking of specific situations that indicate a general problem; as in the case of the clinical addition that at the point where it was turned over to VA by the contractor, had more than $10 million of needed modifications before it could be used. In looking into that situation we learned, for example that under what were standard procedures, the resident engineer for the project at no time had any communication whatever with the facility management, nor any understanding of what was needed to facilitate care, as in one instance, in an intensive care unit. We are aware of another example of a hastily built, large facility that created an absolute nightmare for the staff when it began admitting patients. This particular instance is a classic example of how the Government gets a bad name as to how it spends the taxpayers' money.

We also at one point were made aware of the total lack of a priority review mechanism at Central Office to assure that a project identified as needed at the local level, would still be needed some years later when it had ascended to the top of the priority list.

It is our hope that these, and some other of the failures and lapses in the VA system of identifying, planning and constructing medical facilities are being corrected. It is difficult for us to support the Veterans Administration when it makes what can only be described as indefensible errors.

In conclusion Mr. Chairman and Members of the Committee, we of The American Legion are aware that some of the witnesses to be heard during these hearings will define positions that are directly at odds with the positions of the Legion as we have presented them. We wish it to be known that we truly believe our positions are correct and proper, given the constituency we speak for. We will continue to defend our positions, and it is our sincere hope the Committee will give due consideration not only to what we say, but to why we say it.

Once again, we thank the Committee for the opportunity to present our views.

The
American
Legion

For God and Country

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March 28, 1985

Honorable Frank H. Murkowski
Chairman
Committee on Veterans Affairs
United States Senate
SH 317 Hart Senate Office Bldg.
Washington, DC 20510

Dear Senator Murkowski:

During our appearance before the Senate Committee on Veterans Affairs on March 26, 1985, it was suggested and agreed that we write to you with specific suggestions about ways in which the Veterans Administration could provide more cost-effective health care to the maximum number of veterans who need, apply for and are legally entitled to receive such care. We are pleased to submit some thoughts herein addressing that matter.

May we direct your attention to the specific comment in our statement of March 26, where we say: "It is also our intent to encourage both Congress and VA to foster the development and implemenation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients. The trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible. This enhances both the quality of life provided the patient, and is the most cost-effective method of practicing modern medicine."

Among the treatment techniques and modalities to which we are referring in this statement are the following, which are listed in no particular order and not intended to include all things that may be possible in the practice of "state-of-the-art" medicine.

- Geriatric Evaluation Units
- Adult Day Care Centers
- Respite Care
- Ambulatory Surgery

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- Halfway Houses
- Hospice Units
- Family Counselling
- Residential Home Care Program
- Hospital Based Home Care

The American Legion also supports current VA policy, which is to establish a Treatment Plan for each admitee to a Domiciliary facility, designed to restore the veteran patient to community living as soon as possible. We believe this is not only cost-effective, but will prevent any VA facility from becoming a human warehouse. The only caveat we make to this support is that currently there are some domiciliary patients - relatively few in number we hope - who have already been in the facilities for such lengths of time that they have become "institutionalized," that is, they may now be unable to survive outside an institutional setting. These patients cannot be discharged at this late stage of their lives, and be expected to survive.

We believe the use of all of the new and innovative treatment techniques now available and others still being developed, will be not only cost-effective, but will enable VA to care for a larger number of entitled veterans; so that the Government will be getting more for its money, and more veterans will be getting better care.

If statutory authority needs to be extended to make utilization of such techniques possible, The American Legion will support legislative changes as needed. We believe that would be good legislation.

We have some information that there may be problems with this approach at the Executive Branch level, in that VA asked for funds for the expansion of these kinds of techniques in the FY 1986 budget preparation, and were denied them by the Office of Management and Budget. We would suggest the Committee inquire into this.

Senator, we say again, as we said in our statment of March 26, that The American Legion will support and cooperate with any and all efforts to make VA health care delivery as cost-effective as possible, as long as it is funded and equipped to fulfill its statutory mission in providing health care to American veterans.

We are prepared to discuss and work with the Committee in doing whatever is necessary to foster the enhancement of the practice of modern medicine by the VA's Department of Medicine and Surgery.

May we say again, as we have done on many occasions, that The American Legion continues to rely on the Congress as the most sensitive and responsive Branch of the Federal Government in its concern and care for the men and women who have responded to the call of the elected government to defend the national interest in the nation's Armed Forces.

Sincerely,

R. E. Lynch

R. E. LYNCH, Director
National Veterans Affairs and
Rehabilitation Commission

Chairman MURKOWSKI. Mr. Don Schwab, director of legislation, Veterans of Foreign Wars, our neighbor across the street.

Mr. SCHWAB. Thank you, Mr. Chairman.

Chairman MURKOWSKI. And he is accompanied by Mr. Juarbe.

TESTIMONY OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ACCOMPANIED BY FEDERICO JUARBE, DIRECTOR, NATIONAL VETERANS SERVICE

Mr. SCHWAB. Fed Juarbe who is our director, National Veterans Service.

Chairman MURKOWSKI. We welcome you to the committee. And I might add I appreciated the invitation to address your distinguished membership a few Sundays ago.

Mr. SCHWAB. Appreciated your being there. And thank you, sir. I will summarize the testimony with the understanding it will be published in full.

Chairman MURKOWSKI. It will be entered into the record.

Mr. SCHWAB. Unlike you, Mr. Chairman, or Senator Simpson, who spoke before, we have no great criticism of the VA priority list of 10 most needed hospitals for replacement or renovation. Because as Mr. Alvarez said at a hearing similar to this last year, 53 percent of the VA hospital beds are housed in buildings 30 years or older. So you could almost take a dart and throw it at the map and find a hospital in need of renovation or replacement.

We are unhappy that this ludicrous sage of the Baltimore VA hospital continues. It was approved in 1976. Eight million dollars was spent on acquisition and preparation of the property site. And now the administration talks about going ahead and renovating the Loch Raven facility. We are not at all happy with that.

Mr. Chairman, we keep hearing we have got to cut the VA, we have got to cut the VA. The VA has been cut, Mr. Chairman, and we look to this committee to stand up and tell the administration that.

In 1976, 11.4 percent of the Federal dollars spent on health care were for VA. Now, that has fallen to 8, 9 point—8.9 percent in 1976. In 1975 the VA portion of the Federal budget in outlays was 5.1 percent. For 1986 it is projected at 2.6 percent. So we have been cut over the years.

The dollar amounts have gone up some, but it has been a decremental budget when you plug in inflation. But our percentages of the Federal budget for the VA and for health care have fallen every year since 1975.

Testimony given to this committee and the House committee recently by Dr. Custis, stated that the Office of Management and Budget Guidance with respect to the budget contains the words "shrink the VA system size gradually." Let me tell you, if we are going to downsize hospitals, if we are going to fund 191,000 employees when they are authorized at 193,000, if we are going to cut 2,169 acute care beds, if we are going to sustain continued cuts in the portion of the health-care budget, these things will shrink the VA in size, and not very gradually either.

The VFW has historically maintained that any veteran in need, any wartime veteran in need of medical care should be provided that care by the VA.

A former witness alluded to an article in the U.S. News & World Report recently about patients being dumped by for-profit hospitals onto public hospitals and community hospitals. There was an article this morning in the Wall Street Journal with respect to HMO's going for profit and entering in the same phase as the for-profit hospitals.

If we have enacted all of the reductions recommended by the administration's budget, what it is going to amount to we are going to shrink the VA, we are going to close hospitals, we are going to contract out care for the service-connected, we are going to abandon the non-service-connected to the vagaries of the welfare system. And we just do not think this should happen, Mr. Chairman. And we look to this committee, by golly, to help us and say, "Now just a minute, you know. The VA has had it. We have an obligation and it should be carried out and not cut further."

And that concludes my summary. And I would be happy to respond to any questions you may have, Mr. Chairman.

Chairman **Murkowski**. Thank you.

Mr. Juarbe, do you have a statement?

Mr. **Juarbe**. No, I do not.

Chairman **Murkowski**. What you have said I think bears a very real reflection, but I would call to your attention that you generally support the 10 hospitals that have been selected for priorities. Is that correct?

Mr. **Schwab**. You could pick any 10 really.

Chairman **Murkowski**. Well, I know. But there has got to be some priority because the realities dictate that.

Mr. **Schwab**. You know, we have no quarrel with the 10 as they are. As I said, the Baltimore situation is ridiculous.

Chairman **Murkowski**. Well you know as well as I do, Mr. Schwab, while we have 10 on the wish list we have 1, 2, 3, 4 on the list for major construction projects before us and not the Baltimore project. So we have less than half of what we agreed are our priorities, which, and it is no secret to either you or I, indicates that we are not going to have what we want, nor necessarily what we feel our needs are.

And you have appealed to this committee to act responsibly to address veterans' needs. And I do not shirk that responsibility for a moment. In reality this Nation is faced with a severe crisis—one which could well be one of survival. And that may, in the minds of some, be wishful thinking. However, one only has to reflect the current status of Israel as an example, where 50 cents out of every dollar that is spent by the Israeli Government goes for interest on its debt.

The question there is obviously one of survival. In as much as 25 cents out of every dollar is spent on defense, another 25 cents is left to basically operate the country.

Now, the question that we have as citizens of this country, veteran and nonveteran alike, is just what do we do when we have an emergency such as the emergency that we have currently? And I am not asking for your opinion on whether we should cut the defense budget of this country or cut the social programs. But it seems that reality would dictate that every area of Government is going to have to, for the sake of survival, entertain some cuts.

Now, I am chairing this and in the sense of being practical, we are not going to have, nor are we going to be responsibly able to provide everything that is requested. Therefore, it behooves us to try and increase our efficiency, to look for innovative methods to achieve a higher degree of service. I would implore you and your associates to assist in that process as best you can, because there appears to be no other viable alternative. We can criticize the administration for cutting. And you know, you have done that, and justifiably so. But realism exists, which indicates that for the foreseeable future we are not going to have an increase in overall funding of Government services.

And the question is not one to pose before you as to whether the needs of the country take a certain ranking compared to the needs of Americans in this country and the needs of veterans. It is just a reality that we are going to have to live with. And I guess, Mr. Schwab, I would ask you if you don't see it in that light?

Mr. SCHWAB. Mr. Chairman, my personal opinion, the deficits are horrendous. They are going to do us in if they are not rectified. But when the administration recommends a budget that on the one hand recommends cutting civil service pay and on the other hand recommends increases for other people and puts certain things off limits it is very hard to convince people that everybody is serious about deficit reduction.

Chairman MURKOWSKI. Well, let's get a little more specific. It cut the farmers. And goodness knows, if there is any segment of the American economy that we are dependent on it is the farmers. Now, you can argue about the merits.

You say they have not cut some areas. I would appreciate some enlightenment on where those areas of increase might be?

Mr. SCHWAB. Well, there are areas put off limits

Chairman MURKOWSKI. What? Are you talking about defense?

Mr. SCHWAB. Yes.

Mr. JUARBE. I am not about to address that, Mr. Chairman, but I would like to reflect on what you just said.

I do not believe that there is any fundamental difference between what this committee and you, as its Chairman, and the Veterans of Foreign Wars has attempted to do. I think we are both very sincerely approaching along with the administration how to provide care in an equitable and cost-efficient manner for all of our Nation's veterans that require that care, first the service-connected and then the non-service-connected, that for economic means are not capable of providing that care for themselves.

I think where we differ is in the fundamental philosophical differences as to how we go about it.

Chairman MURKOWSKI. Well, there is only so much money and it will only go so far.

Mr. JUARBE. Well, Mr. Chairman, we, our Nation has a tradition of providing for the social and economic needs of those who are needy in our society. At present it is trying to address that through this committee and through the Veterans 'Administration for veterans, through other committees and through other means for the population at large.

I think if we refer to the U.S. News & World Report article that we make reference to in our testimony you will note that there are approximately 28 million people in our Nation that are medically indigent. Now, it is obvious that the private sector is not providing care in an effective manner for them. That article goes on to site that the overbedded capacity that the private, for-profit sector has has no interest in providing care for these people.

The public hospitals and teaching hospitals are——

Chairman MURKOWSKI. I know. I do not disagree with you—the point is, we are going to have less to go around, but we are still going to have the need. So the implication is everybody is going to have to take some kind of a proportional cut. Is that not the case?

Mr. JUARBE. Well, before I answer that specific question let me go back to what Senator Rockefeller and Dr. Ditzler referred to before, that care within the VA health-care system is much more cost-effective than care within the Medicare system. As it is, the Medicare system and Medicaid is not capable of providing care adequately for all the demands that are placed upon it.

What we are doing by reducing the capacity of the VA to provide care for veterans is placing those veterans in competition with that private-sector segment, but that is not providing care.

Chairman MURKOWSKI. Would you suggest that the Veterans' Committee hold open hearings to try and resolve the debate on who has the cheapest health care in this country?

Mr. JUARBE. I believe the time has come for that. We have asked——

Chairman MURKOWSKI. Would you support that?

Mr. JUARBE. I think the——

Chairman MURKOWSKI. Would your organization support that?

Mr. JUARBE. I believe the—we would support a public debate to determine whether VA health care is much more cost effective. It is our belief that it is.

If we stop comparing apples and oranges, as Dr. Ditzler indicated before. We have——

Chairman MURKOWSKI. I assume that we are smart enough to figure out which are the oranges and which are the apples.

Mr. JUARBE. I would think so. Up to now that has not been done.

Chairman MURKOWSKI. Well, maybe that is what we should do. And I think it would be appropriate for this committee to consider that and end this dilemma once and for all. Because if, in fact, VA health care is that much more efficient and that much cheaper, obviously it is in the Government's best interest to expand that system at the expense of the other systems.

Mr. JUARBE. Well, let's go back to your original question, Mr. Chairman, whether the VA should share in cuts. I, as a representative of over 2 million veterans and a major segment of our Nation's veterans and a representative protecting the interests of veterans, the welfare of veterans, I do not believe it is our position to agree or indicate just where the VA should cut. However, I think the committee has——

Chairman MURKOWSKI. You would rather leave that up to Congress then?

Mr. **Juarbe**. Well, I believe Congress has a very good point in reviewing and considering the adequate pricing of VA facilities.

Chairman **Murkowski**. I know, but Congress does not have to run the organizations that you have to run. You get the feedback from your veterans.

Mr. **Juarbe**. And through the public debate process, through hearings such as these we have an opportunity to identify the needs and indicate whether we are——

Chairman **Murkowski**. But the realities are the word is out everybody has got to take cuts.

Mr. **Schwab**. In spite of the fact that we have been taking cuts for 10 years.

Chairman **Murkowski**. Everybody has been taking cuts in one form or another.

Mr. **Schwab**. Well, I—that cannot be so because somebody is getting our portion of the health-care budget that we no longer get. Somebody is getting our portion of the Federal budget that we no longer get. This has been going on for 10 years. OMB has, you know, proposed to downsize the VA.

Chairman **Murkowski**. Well I do not think we ought to play with figures because I can show you that your grand total budget in 1974 was $15 billion and it is $27 billion now. We can go back and debate the issue of inflation, and so forth, and so on. But it has not gone down, it has gone up. The service requirements have gone up, as appropriately they should be.

I think we have exercised this area enough. I think that your constructive suggestion that we enter into trying to resolve the difference of who can provide health care the cheapest in this country and the statement that you would support such a study or public debate is well worth the consideration of my colleagues. I will bring this up at the next business meeting to see if indeed they would feel that we could get something constructive addressed.

And I want to thank you as representatives of the VFW for indicating your support for such public examination. Thank you very much.

Mr. **Juarbe**. Mr. Chairman, if I may, just one last comment. I think along with that public debate we must also answer the question as to will the other systems that are available to provide care for the medically indigent be sufficient to provide care for those veterans that would be displaced through a downsized system.

Chairman **Murkowski**. I am going to ask that Mr. Principi call the next witness. I have some people outside that I am going to have to say hello to. I will come back as soon as I have concluded that.

Mr. David Gorman and Mr. Bob Moran.

Mr. Gorman is assistant national legislative director of the Disabled American Veterans.

Mr. Bob Moran is associate legislative director of the Paralyzed Veterans of America.

Mr. **Schwab**. Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you very much, gentlemen.

Mr. **Juarbe**. Thank you.

Chairman **Murkowski**. Thank you, Mr. Schwab.

[The prepared statement of Donald H. Schwab, director, national legislative service, Veterans of Foreign Wars of the United States, follows:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

PREPARED STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 2 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the Veterans of Foreign Wars has historically had a vested interest in the Veterans Administration's construction program and our constituency has a parochial interest in all of the construction projects listed in the Fiscal Year 1985-1989 Five-Year Medical Facility Construction Needs Assessment. As required by 38 USC 5007, this report lists, among other construction projects, the medical centers currently judged most in need of construction, replacement or major modernization. These facilities are: Houston, Texas; Allen Park, Michigan; Mountain Home, Tennessee; Pittsburgh (Aspinwall Division), Pennsylvania;

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Augusta (Uptown Division), Georgia; Gainesville, Florida; Baltimore (Loch Raven), Maryland; Palm Beach County, Florida; Philadelphia, Pennsylvania; and Dallas, Texas.

Mr. Chairman, the reduced construction budget will permit replacement and modernization of hospitals at Houston, Texas, and Mountain Home, Tennessee. The new Houston facility will house 1,047 beds, including 120 nursing home care beds and 40 spinal cord injury beds. The Mountain Home project will consist of 530 beds including 73 existing psychiatric beds and replacing buildings constructed during 1903-1908 and 1937. Also proposed is a 240-bed nursing home care unit, surface parking and a pedestrian bridge at the Philadelphia, Pennsylvania Medical Center. In addition, the budget provides for 120-bed nursing home care units at Amarillo, Texas, and Tucson, Arizona; 408-bed replacement domiciliary at Temple, Texas; and renovation of Building 43 at the Wood, Wisconsin Medical Center to provide 192 domiciliary beds and related support functions.

The need for the above major construction projects, as well as those not funded, has been fully justified by the Veterans Administration and verified by our Field Representatives whose primary duty is to survey Veterans Administration medical facilities.

Mr. Chairman, informal information indicates consideration may be given to down sizing the Houston replacement hospital to provide funds for the Philadelphia hospital. You will recall that under the bed-sizing formula worked out by your Committee last year, the number of beds in five proposed hospitals would be reduced to permit the replacement or modernization of seven hospitals. For example, the Houston hospital would be cut to 805 beds for a projected cost savings of some $56.4 million. Although there may possibly be hospitals in the future which might be down sized due to a drastic change in demographics, Houston is not one of them. This facility, presently with 1,006 average-operating beds, has an average daily census of 880 and a bed occupancy rate of 87.5 percent. In addition, the cost of redesigning the hospital coupled with inflation creep in the two- to three-year interim could well consume the projected cost savings from down sizing. The VFW, therefore, strongly recommends that the Houston replacement hospital be funded and built with the 1,049-bed capacity as recommended in the President's proposed budget. Our position is the same with respect to the Mountain Home hospital which the Committee's formula would cut from 530 beds to 387 beds.

Mr. Chairman, the ongoing saga of a replacement hospital in the Baltimore-metropolitan area is ludicrous and should be an embarrassment to all concerned. On May 11, 1976, President Ford announced that a 400-bed hospital would be built in Baltimore. Funds for planning and design were appropriated in the fiscal year 1977 and construction funds in the fiscal year 1980. Construction was to have commenced between June and October, 1980, with 1983 targeted for completion. The Veterans Administration has spent $8 million on this project--$3.5 million for working drawings and $4.5 million for the purchase of the construction site. However, the project was cancelled when the President included the construction funds in a 1981 rescission message. Now, the Administration proposes to modernize the 33-year old Loch Raven Medical Center constructed as a tuberculosis long-term treatment facility. The Veterans Administration anticipates it will have developed a construction plan and schedule when the next Five-Year Medical Facility Construction Needs Assessment is published. It is, however, common knowledge that Loch Raven will need the most extensive renovation and for this reason, the VFW continues to support construction of the original 400-bed hospital upon which $8 million has already been expended.

Mr. Chairman, proposed for the fiscal year 1985 was a 60-bed nursing home care unit at the Providence, Rhode Island Medical Center at an estimated cost of

$5.2 million. However, a General Accounting Office report entitled "VA Justification for Two Nursing Home Care Projects in Its Fiscal Year 1985 Budget Request," dated May 15, 1984, stated that the Providence project did not appear to be needed. Further, it was asserted that the VA did not adequately consider that the Providence area will have an ample supply of community and State home nursing beds to meet the requirement of veterans in 1990. The report also stated that on May 11, 1984, Dr. John Gronvall, the Acting Chief Medical Director, advised the General Accounting Office that he had recommended to the Administrator that the project be deleted from the fiscal year 1985 budget request. Members of our VFW National Veterans Service attended the Chief Medical Directors Meeting on May 22, 1984, at which time Dr. Gronvall was quick to clarify that he did not, repeat, did not indicate to the General Accounting Office that he concurred with their findings; this was the result of a breakdown in communication and incorrect information given by a member of his staff. The justification given in the fiscal year 1984 budget for this construction was the dearth of nursing home care beds within the VA system in District 1. There are presently 55 nursing home care units under contract in Providence. One of our Field Representatives visited the Rhode Island Veterans Home in Bristol on January 11, 1985, where there are 271 nursing care beds and 49 domiciliary beds. The VFW believes that the primary source of nursing care beds should be within the VA system with State and community beds being used only as a supplement, not as the primary source of such beds. Therefore, we urge serious reconsideration and approval of this project.

Mr. Chairman, according to testimony given by Dr. Donald L. Custis last month, the Office of Management and Budget Guidance with respect to the budget contains the words "shrink the VA system size gradually." Down sizing hospitals will accomplish this end. Funding to support only 191,849 full-time equivalent employees (FTEEs) while allocated 193,941 FTEEs will accomplish this end. Reducing 2,169 acute care beds will accomplish this end. Continuing to reduce the percentage of Federal outlays for health care for veterans (from 11.4 percent in 1976 to 8.9 percent estimated for 1986) will accomplish this end. Doing these things will definitely accomplish this most unworthy end.

All of the above actions are opposed by the VFW. We have historically maintained that honorably discharged veterans with wartime service in need of medical care should be furnished that care by the Veterans Administration without further cost to the veteran. Obviously, the VFW does not support bed sizing to accomodate only those with service connected disabilities and those on the pension roll. Neither do we view as tenable the premise that projects of over 700 hospital beds are too large. Some fourteen VA medical centers of over 1,000 beds each have been functioning quite well over the years.

It is unfortunate that the Committee was unable to reach agreement and submit a committee report to the Budget Committee. It is also regrettable that the letter from the majority members to the Budget Committee stated under medical construction only that: "The majority members cannot at this time make any recommendations regarding the VA's construction programs."

Mr. Chairman, the VFW believes it most imprudent to consider curtailing construction. As the Deputy Administrator, the Honorable Everett Alverez, Jr., pointed out in a similar hearing last March, the VA is in a catch-up situation with respect to construction. Further, "...most VA facilities now have buildings over 30-years old. Indeed, 53 percent of VA hospital beds are housed in buildings over 30 years of age. The majority of VA medical centers also were constructed without significant outpatient capability and substantial changes in fire safety codes and related requirements have been made since the original construction."

We see a direct link between the proposed construction budget, to include the developing VA health care facilities construction policies within the Administration, and future veterans health policy in general. We note that this Committee has addressed a number of questions to the VA witnesses which would generally come under the rubric of health policy rather than the specific area of construction. We would like to commend the Committee's astuteness in, what we hopefully project to be, its recognition of the insidious effort by the Administration to implement a policy which would initially cap the system, but in the long run actually down size it. This would be accomplished through deterioration and attrition to the point where it will neither have the acute care nor long-term care beds necessary to provide care for most veterans. The purpose being to dismantle the veterans health care system.

As the first step in this direction, we see the Office of Management and Budget's "Freeze Plus" proposal to limit construction of VA health care facilities to two major renovations per year. Such a policy clearly goes beyond just capping the system. The VA would obviously not be able to provide state-of-the-art health care since its physical plant would no longer be able to accommodate modern medical technology.

With 172 hospitals and the average physical plant lifespan being 40 to 50 years, it would take over 86 years before a hospital would be considered for renovation or modernization again. Clearly, this would place most facilities in an untenable position with regard to fire and safety, space, quality of life, and maintenance; all of which would put in jeopardy the accreditation standing of each facility.

In fact, this problem is being faced now and can only be expected to worsen in the next 15 years. As a result, the Veterans Administration will effectively lose its capability to provide care within the system whether in acute care or long-term care beds. Granted, that while renovations and replacements may be severely limited, funds would be made available for upgrading given sections or buildings in each facility. However, we see this only as patchwork which would eventually prove wholly inadequate. The end result being that increasing numbers of bed sections will be closed as a result of failing to meet the criteria of the Joint Commission on Accreditation of Hospitals and other standards. This reduced capacity would snowball to the point where the VA would care for fewer and fewer veterans, requiring fewer personnel. This would eventually lead to the total outplacement (mainstreaming) of the nonservice connected veteran and provision of care for the service connected veteran through voucher systems.

Greater emphasis has recently been placed on the need to consider veterans health policy in conjunction with existing national health policy. As a matter of fact, it is my understanding there will be a joint hearing of the House Select Committee on Aging and the House Veterans' Affairs Committee next month. As a result, we must consider the implications of the development of a veteran's health policy which increases reliance on the private sector either as a result of tighter eligibilities, reduced capacity within the VA or increased sharing of community resources through contract arrangements. The outplacement of veterans puts a higher premium on private sector capability. While we recognize that the private sector in general is grossly overbedded, this is usually in the for-profit area while the capacity of charity wards is totally inadequate for the medically indigent. Such displaced veterans will obviously be in competition with aged women in the private sector who will greatly outnumber older veterans. Furthermore, this will place increasing demands on tenuous health-care payment systems such as Medicare and Medicaid.

A U.S. News and World Report article of March 18, 1985, entitled "Hospitals: A Sick Industry," states that "...more than 12 percent of Americans--28 million people--have problems getting medical treatment, largely because of a lack of insurance. Hardest hit by the burden of providing free care are public and teaching hospitals in major cities with large numbers of the poor and the unemployed. With an eye on the bottom line, private hospitals tend to limit their charity care and end up transferring a certain number of indigent patients to public facilities." The article goes on to cite the serious health hazards and ethical implications arising from the dumping of patients. It was noted that a significant number of these patients transferred from private hospitals to public hospitals' emergency rooms experienced substandard care.

Another factor to be considered is that a deteriorated VA physical plant means diminished DoD backup capability. This fourth major mission is enunciated in Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," approved by the President on May 4, 1982.

The Administration's current health care policy for veterans is a shortsighted quick fix with serious ramifications for the future, transcending the veteran's community and adversely impacting on future national health care policy. We envision attempts to change and restrict eligibility through the implementation of a means test, including veterans over age 65; third-party reimbursement and other such devices as an Administration ploy which, if achieved, will be a grave disservice to our Nation's veterans. But, this may be politically volatile. Unfortunately, an easier means of reducing the VA health care system is through the backdoor by fully implementing current construction policy.

Mr. Chairman, the Veterans Administration's report entitled "Caring for the Older Veteran" makes it patently clear that this Committee, indeed, this 99th Congress, cannot march in lock step with the Administration with respect to proposed cuts and still fulfill the Nation's fundamental commitments to its war veterans--one of the continuing costs of war.

Appended to my testimony are the following resolutions addressing Veterans Administration's construction passed by the voting delegates to our most recent National Convention:

Resolution No. 670 -- "Replacement of Veterans Administration Medical Center, Allen Park, MI"

Resolution No. 678 -- "V.A. Medical Facilities for Northern California"

Resolution No. 689 -- "Establishment of VA Outpatient Clinic, Savannah, Georgia"

Resolution No. 707 -- "Construction of Parking Ramp"

Resolution No. 725 -- "Construction of New or Enlargement of Outpatient Clinic, McAllen, Texas"

Thank you and I will be happy to respond to any questions you may have.

Resolution No. 670

REPLACEMENT OF VETERANS ADMINISTRATION MEDICAL CENTER, ALLEN PARK, MI.

WHEREAS, for the past seventeen years, the Department of Michigan, Veterans of Foreign Wars of the United States, has made attempts to have the Veterans Administration Medical Center, Allen Park, Michigan, replaced with a new facility; and

WHEREAS, Veterans of Foreign Wars' hospital surveys conducted in February, 1975, and again in February, 1978, revealed findings that justified replacement of the Allen Park facility; and

WHEREAS, the VFW's findings and conclusions were confirmed by a special study released in the latter part of 1978 (identified as the Rossetti Report), conducted on orders from the Congress of the United States; and

WHEREAS, in compliance with Public Law 96-22, Section 5007, the Veterans Administration has announced a list of ten hospitals most in need of construction, replacement or major modernization, and Allen Park is ranked number six; and

WHEREAS, in response, the VA is now engaged in a comprehensive study of this facility, but it is fearful that an effort will be made to modernize this station to save construction dollars over the next five years without regard for the fact that the Allen Park Hospital has built-in deficiencies that cannot be corrected; and

WHEREAS, over a period of time from a cost effectiveness aspect, it would cost the VA more to operate this hospital than it would be to build a new medical center adjacent to Wayne State School of Medicine; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that the Administration of Veterans Affairs be urged to seek funds for the replacement of the Allen Park Veterans Administration Medical Center to be constructed adjacent to the Wayne State School of Medicine, Detroit, Michigan; and

BE IT FURTHER RESOLVED, that the Allen Park Veterans Administration Medical Center not be closed after the new hospital becomes operational but be used for treatment of psychiatric disorders, intermediate care, nursing care, domiciliary care, and regional office activities.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 670

Resolution No. 678

V.A. MEDICAL FACILITIES FOR NORTHERN CALIFORNIA

WHEREAS, there are many veterans in Northern California; and

WHEREAS, many veterans are reaching retirement age and moving to Northern California and in need of medical assistance; and

WHEREAS, V.A. medical facilities are many miles away, causing hardships in traveling to these facilities; and

WHEREAS, Redding, California, is a medical center for Northern California and has access to all modes of transportation to and from Redding; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress of the United States to establish a V.A. Medical facility in Redding, California.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 678

Resolution No. 689

ESTABLISHMENT OF VA OUTPATIENT CLINIC, SAVANNAH, GEORGIA

WHEREAS, the 30,000 plus veterans residing in the Savannah tri-county area are required to travel many miles for medical care at the VA Medical Center in Charleston, South Carolina or at the VA Outpatient Clinic in Jacksonville, Florida; and

WHEREAS, the Veterans Administration has after many years recognized that a medical care outpatient clinic is needed in the Savannah area when Mr. Harry Walters, Administrator of Veterans Administration, did approve a facility, subject to congressional appropriation of necessary funding; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we urge Congress to assist in every possible way to allow these funds to be released during FY 1986 so that this clinic will become a reality.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 689

Resolution No. 707

CONSTRUCTION OF PARKING RAMP

WHEREAS, the U.S. Veterans Administration Medical Center at Buffalo, New York, services veterans within a radius of about 100 miles; and

WHEREAS, the in-house patients number around 800, the staff and employees about 1,700 and the parking facility will accomodate only 875 vehicles, there is little if any room for visitors and volunteers to park their vehicles; and

WHEREAS, it is virtually impossible to find a parking space on the premises of the VA Medical Center at Buffalo, New York, between the hours of 8:00 AM and 4:30 PM, Monday through Friday; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we petition the Congress of the United States to make available funds for the construction of a parking ramp adjacent to the VA Medical Center at Buffalo, New York, sufficient in size to accomodate the automobile parking requirement of the many veterans, visitors and staff who utilize that facility.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois August 17-24, 1984.

Resolution No. 707

Resolution No. 725

CONSTRUCTION OF NEW OR ENLARGEMENT OF OUTPATIENT CLINIC, McALLEN, TEXAS

WHEREAS, the State of Texas now has over 1,732,000 veterans in the McAllen area, there are over 39,900 in the counties utilizing the Outpatient Clinic which does not include those veterans living across the border in Mexico; and

WHEREAS, the Veterans Administration has now released figures showing that there are now over 63,000 veterans residing in the area who have potential eligibility for care by the Veterans Administration; and

WHEREAS, the Lower Rio Grande Valley is rapidly becoming a mecca for veterans who enjoy the south, particularly in the winter months and during this period, the veteran population from September to June doubles which causes an additional burden on the existing facilities at the VA Outpatient Clinic; and

WHEREAS, the closest VA Medical Center is the Audie L. Murphy Medical facility located in San Antonio, Texas which is 240 miles from the McAllen Texas Outpatient Clinic and the VA currently does not have any fee basis beds in local medical facilities; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we go on record in supporting action to either enlarge or construct an adequate outpatient facility to provide at least 50,000 outpatient visits per year or an outpatient facility plus a bed section of at least 250 beds to accommodate the needs of the veterans in the Lower Rio Grande Valley, State of Texas.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 725

Mr. PRINCIPI [presiding]. Dave, would you like to proceed?

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF: DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS, AND BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. GORMAN. Thank you, Mr. Principi, I surely would.

On behalf of the 780,000 members of the DAV I certainly want to say it is our privilege to appear before the committee this morning to discuss the issue of VA construction and health-care policies in general.

Mr. Chief Counsel, I believe our written testimony, which will be made a part of the record, sets forth in considerable detail our thoughts on the entire VA health-care system and how it relates to the construction program specifically, and because I know we are constrained for time, I will try to summarize very briefly some of our primary concerns and points.

We feel, specifically, that the quality of care that is delivered to this Nation's veterans depends in large part upon the provision and the existence of modern, safe, and efficient medical care facilities comprised within the VA medical care system.

We do advocate and recommend, not a wholesale construction program, but rather to provide within the VA system for a reasonable expansion, renovation, modernization, and replacement program that would best benefit the taxpayers' dollars. We feel, as we have heard testimony today, the current system and the capital plant facility of the VA, which comprises about 5,000 separate buildings, represents a multibillion-dollar investment by the American taxpayers. And it is also important to keep in mind that the vast majority of veterans are American taxpayers also.

We think that by providing this kind of a modern, safe environment in VA medical facilities that it will continue to attract quality health-care professionals that we think are needed to keep the VA medical system viable.

The VA is very active in the affiliation programs and trains about one-third of the medical school students each year and well over 100,000 health-care professionals each year. Additionally, they are very actively involved in all aspects of medical and rehabilitative research efforts, to include many innovative things such as CAT scanning and the first cardiac pacemaker that was implanted in a human being was done at the Buffalo VA Hospital.

We would mention that in the 1986 budget the VA is considering and will convert 206 acute care hospital beds into nursing home beds. We support in theory the conversion process. But we would just caution that in view of the aging veteran problem, the need for additional nursing home care beds. There is also a need to maintain an appropriate balance of acute care beds within the system. And we would simply caution the VA not to move ahead too fast without keeping in mind the need for that kind of a balance.

Mr. Chief Counsel, we have a few items that again are detailed in our statement that we would like to discuss briefly. And we have heard some testimony this morning, that is, the prioritization method of which the VA plans their future construction needs.

We understand that a prioritization methodology report is to be submitted to Congress, if it has not already. And although we cannot endorse that methodology report in toto until we have had a chance to review it, we would certainly agree to the concept, in theory, of a prioritization method.

The second specific we would like to discuss now is the VA's prototype nursing home design that was implemented, on paper anyway, back a couple years ago. As we understand the prototype nursing home, it has the capabilities to be adaptable nationwide in the construction of nursing homes while still being able to adapt to various variables that would be geographically necessary. We also are led to believe that there is a considerable cost avoidance by using this prototype nursing home concept and, also, a considerable time savings from the time that the project is identified to construction that only serves to benefit the veteran population.

The last thing I would like to discuss is the VA's authority to acquire existing medical care facilities and bring them into the VA hospital system. While we do not advocate having the VA go out and purchase on a wholesale or arbitrary basis existing medical facilities, we do agree in concept and theory to the fact that when there is a documented need in a certain area of the country based on veterans' needs for medical care treatment and there is, as an option to construction, an existing facility that they would consider acquiring that as opposed to construction. We think they should be using that authority.

That concludes my statement, Mr. Chairman.

Mr. PRINCIPI. Thank you, Mr. Gorman.

[The prepared statement of David W. Gorman, assistant national legislative director for medical affairs, Disabled American Veterans, follows:]

PREPARED STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 973,000 members of the Disabled American Veterans, I would like to take this opportunity to thank you and the members of the Committee for allowing us the opportunity to present our views on the VA's medical construction program.

In your letter of invitation to testify, our views were solicited on the major policies pertaining to VA medical facility construction, as well as the full range of relevant issues pertaining to the construction program.

Mr. Chairman, the DAV believes it important to place the Veterans Administration medical care program--Department of Medicine and Surgery (DM&S)--in its proper context to the delivery of health care, in general, and to veterans, in particular.

The stated mission of DM&S is "to ensure that quality medical care is provided on a timely basis within the law to all authorized veterans."

This mission is formulated to provide:

1. a complete medical and hospital service for the medical and hospital care of veterans;
2. a program of education and training of health care personnel;
3. a program of medical research; and
4. health care services to members of the Armed Forces during a war or national emergency.

Mr. Chairman, in our opinion, the delivery of quality health care to this nation's veteran population entails a commitment to modern, safe and efficient medical care facilities.

Presently, the VA's health care system is comprised of 172 medical centers, 226 outpatient clinics, 116 nursing home units and 16 domiciliaries. Approximately 194,000 individuals are employed by DM&S including: 12,100 physicians, 1,046 dentists, 1,440 psychologists, 32,600 nurses, 9,600 licensed practical nurses and 18,100 nursing assistants.

Currently, there are approximately 28 million living veterans, of which, about three million individual veterans were VA patients during 1983.

Within current statutory framework, the VA is authorized to furnish medical treatment to the following:

1. to any veteran for a service-connected disability;

2. to any veteran (for any disability) who has a service-connected disability rated at 50% or more;
3. former prisoners-of-war;
4. veterans entitled to nonservice-connection pension;
5. World War I, Spanish American War and Mexican Border Period veterans;
6. Vietnam veterans exposed to certain herbicides, i.e. Agent Orange;
7. veterans exposed to ionizing radiation (atomic veterans);
8. any veteran 65 years of age or older for a nonservice-connected disability; and
9. any veteran for a nonservice-connected disability if unable to defray the costs of necessary treatment.

Mr. Chairman, the VA will treat, on an inpatient basis, an estimated 1,409,394 veterans in Fiscal Year 1986, representing an increase of 3,211 from 1985. This total includes approximately 20,000 veterans (an increase of 1,700) to be treated in VA nursing home care units while maintaining an average daily census of 10,841 (an increase of 866 over 1985 levels). Additionally, 18,797,000 outpatient medical visits are estimated to occur in Fiscal Year 1986 (an increase of 112,000 over the 1985 level).

The above, Mr. Chairman, illustrates, albeit briefly, the general scope, responsibility, and work load encompassed in the VA medical care program. Suffice it to say, the VA's Department of Medicine and Surgery is the nation's largest integrated comprehensive total medical care system in the country. It is the only system capable of providing a full array of health care services to eligible veterans.

Contrary to the varied assertions voiced by a variety of individuals and sources, the VA medical care system has, is, and will continue to treat veterans who are, in the vast majority, service-connected and/or medically indigent. Only one in nine veterans--slightly more than 10%--have ever availed themselves of VA medical care.

Mr. Chairman, it seems abundantly clear, for a variety of reasons, that the VA's estimation of 12 million veterans (service-connected, those in receipt of nonservice-connected pension, those age 65 or over, or those who are unable to defray the cost of private medical care) eligible for VA medical care and treatment will not access into the system during their lifetime.

Clearly, fiscal constraints and finite federal dollars, in conjunction with established priorities and the freedom of choice of some veterans to receive medical care elsewhere, have dictated and will continue to dictate how many veterans enter the system.

From Fiscal Year 1975 ($3.5 million) to Fiscal Year 1985 ($9.2 million), the VA health care budget has nearly tripled in total actual dollars. However, once deflated to reflect movement in the Consumer Price Index, we view a virtual solid straight-line budget.

During 1983, Americans spent an unprecedented $355.4 billion for health care. This represents an annual rise in health care costs of approximately 10% in 1983, compared to a rise of 12.5% in 1982, and a record breaking 15.3% in 1980. For the ten year period, 1972 through 1982, health spending rose an average of 13.1% per year.

A comparison of VA health care dollars, as a percent of the total federal outlays for health, Medicare and veterans' hospital and medical care, reveals a decline from 11.4% in 1976 to an estimated 8.9% in Fiscal Year 1986.

Mr. Chairman, during the 35 year period from 1950 to the present, the Veterans Administration has only experienced a three-fold increase in its budget, compared to some human resource programs that have increased anywhere from 28-fold to 345-fold.

During this time frame, we have witnessed two major armed conflicts--Korea and Vietnam--that increased the veteran population from 18.5 million to 28 million, saw two major G.I. Bill programs that educated thousands of veterans and benefitted from 22 major veterans' health care measures that were enacted into law by the Congress. We also saw the addition of 29 hospitals to the VA system.

Mr. Chairman, the budgetary restraints historically imposed upon the system are, in our view, quite clear. The question that remains is, are the American taxpayers--which include almost all veterans--getting their money's worth out of the system? In terms of quality of care and cost efficiency, the answer must be in the affirmative.

As an illustration, during December, 1983, the Denver, Colorado, VA Medical Center experienced a water main break resulting in the emergency evacuation of 227 patients for a five day period to 15 civilian hospitals and one Army Medical Center.

Without reciting specific costs involved, it was calculated that the VA reimbursed the hospitals involved $240,570 more for inpatient costs and $1,563 more in outpatient costs than it would have cost the government to maintain these same patients in the Denver VA Medical Center.

When extrapolating these costs, it was concluded that the total difference in costs projected over a year's period for inpatient and outpatient episodes of care at civilian hospitals versus the Denver VA Medical Center would cost the American taxpayers an additional $30,829,575.

Mr. Chairman, in addition to the VA's charge to provide quality health care to veterans, an integral part of the VA's mission includes the education and training of health care personnel.

Today, 104 medical schools enjoy an active affiliation with 130 VA medical centers. Approximately 100,000 students, encompassing all health care disciplines, receive a portion of their training under the auspices of the VA. Additionally, one third of all medical students are trained in VA medical care facilities.

An often unknown fact, and, until recently, a virtually untold story, is the VA's role and accomplishments in medical and rehabilitative research. In addition to the numerous and prestigious awards bestowed on VA researchers, two, in particular, stand out:

> In 1977, Rosalind S. Yalow, Ph.D., of the Bronx, New York, VA Medical Center and Alexander V. Schally, Ph.D., of the New Orleans, Louisiana, VA Medical Center, shared the Nobel Prize for Medicine for their respective works with radioisotopes and on the endocrine system.

In 1945, the VA embarked on research efforts regarding what was known as the "white death"--tuberculosis. This research not only revolutionized the treatment of tuberculosis, but was responsible for the development of an innovative method of testing the effectiveness of new drugs and therapeutic protocols that helped to eliminate tuberculosis as a major public health problem. The results of this research and the saving of lives and tax dollars are virtually incalculable.

Mr. Chairman, the VA remains active in research that has provided computer assisted tomography (CAT scanning) and major breakthroughs in the treatment of mental illness, hypertension, kidney disease, the effects of aging, exposure to Agent Orange and delayed stress syndrome, primarily among Vietnam veterans. The first cardiac pacemaker implanted in a human was accomplished at the Buffalo, New York, VA Medical Center.

Similarly, rehabilitative research in the areas of prosthetics, spinal cord injury and audiology and speech pathology have proved invaluable toward the VA's goal of improving the quality of life of disabled veterans.

Originating in the VA, the concept of immediate post-surgical fitting of lower extremity prostheses, together with early ambulation, decreased the mortality rate at one VA medical center from 16% to 0% while, simultaneously, increasing the rate of rehabilitation from 81% to 100%. Significantly, the interval of time between the original amputation and fitting of a permanent prosthesis was reduced from 125 days to 32 days.

Mr. Chairman, while seemingly the tone and thrust of my testimony thus far has tended to stray from the subject of this hearing--the policy pertaining to VA medical facility construction--I assure you the opposite is true.

Earlier in my testimony it was proffered that the VA Department of Medicine and Surgery's primary mission of providing quality health care encompasses a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on a continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities.

To do less, Mr. Chairman, would, in our view, jeopardize and ultimately dismantle the VA system. Without active affiliations and programs of education, training and research efforts--which serve as highly successful vehicles to attract quality health care providers--the quality of care provided by the VA would not exist to the potential necessary to make the system viable.

The Congressional mandate that the VA act as the primary source of medical care backup to the Department of Defense would be, for all practical purposes, nullified absent medical construction funds to maintain the physical plant facilities of the VA's 5,000 separate buildings.

As you know, Mr. Chairman, the VA's request for construction programs in Fiscal Year 1986 calls for budget authority of $611.6 million, of which, approximately $552.9 million is devoted to the health care system. While the total program level requested is

$771.6 million, this figure seems artificially inflated due to the proposal to reprogram $160 million in prior budget authority from the major working reserve.

Highlights of the medical construction program include:

- $261 million in replacement and modernization projects;
- $188.5 million in general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements in support services;
- $52.4 million in clinical improvements;
- $42.2 million in fire and safety improvements;
- $23.7 million to increase domiciliary capabilities;
- $23.3 million to increase nursing home care capabilities; and
- $2 million for outpatient improvements.

When reviewing the VA's Fiscal Year 1986 construction request for medical programs, it becomes evident that the agency's ability to provide quality care is being placed in jeopardy.

Simply stated, Mr. Chairman, while we support full funding of the proposed construction program we are nevertheless concerned, not only with the quality of care provided, but also concerned about the VA's ability to meet the pressing demands being placed upon the health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, only 4.2% ($23.3 million) is requested for nursing home care bed construction, conversion, renovation and relocation.

We are aware of and support the VA's proposal to convert 204 hospital beds to nursing home care beds, as well as efforts to replace and modernize other nursing home care facilities. While the VA is considering the conversion of a few acute care beds within hospitals, their plans may be directed more at "change of missions"--conversions of entire hospitals.

Mr. Chairman, the DAV will not, in every instance, oppose the VA's plans to change the mission of certain VA hospitals. However, as the demand rapidly increases for nursing home care beds, we would urge the VA to proceed on a swift timetable concerning conversion of beds, while maintaining an appropriate balance to meet the acute and intermediate health care needs of all veterans, including our aging veteran population.

The DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1986 budget projects the loss of 1,000 additional hospital beds next year. This proposed reduction will bring the total loss of hospital beds within the confines of the system to 4,500 since 1981. Conversely, the VA has added only 2,800 nursing home care beds to the system over the same period.

Mr. Chairman, an obvious violation of Section 5010(a)(1), Title 38, United States Code, exists by virtue of the fact that the VA is now operating and maintaining 89,100 hospital and nursing home care beds. Additionally, when viewing the five year pattern mentioned earlier, it becomes obvious that a greater number of hospital beds are being closed than nursing home care beds are being added to the system--a net loss of 1,700 beds since 1981.

In our view, the continued shutdown of beds is simply a waste of available resources. Considering the current demand for nursing home care and the rate at which nursing care beds are added to the system, we would encourage the VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing care beds.

As you know, Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district perspective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning process embodied in MEDIPP--making the most cost effective use of resources and funding that is available. The program should continue to provide input in the construction planning process.

The VA's Fiscal Year 1986 construction request includes $19 million for the Advance Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting $20 million in Fiscal Year 1986 for the Design Fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, an average delay of 15 months may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary costs.

Mr. Chairman, if in fact the flexibility provided by the APF is present and beneficial, and taxpayer dollars are saved by eliminating unwarranted delays as suggested by the mechanics of the Design Fund, then the DAV can support full funding of these items in the construction budget.

The VA's Fiscal Year 1986 request for grants for construction of state extended home care facilities is $22 million, a dramatic decrease of $12.5 million from the Fiscal Year 1985 level of $33.5 million.

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, or hospital care to veterans in state homes.

Under the current program, a grant may not exceed 65% of the total costs of the project and grants to any one state may not exceed one third of the amount appropriated in any one fiscal year.

The VA's Fiscal Year 1986 request of $22 million will provide for an additional 450 nursing home beds, as well as 126 convertible domiciliary/nursing home beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans' homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system as discussed earlier.

During Fiscal Year 1985, state veterans' homes will maintain an average daily census of 8,200 nursing home, 4,469 domiciliary, and 516 hospital patients. In Fiscal Year 1986, state nursing homes and domiciliaries average daily census is projected to increase by 618 and 248, respectively.

Recognizing the significance and important role of state veterans' homes--in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program--we believe it is indeed shortsighted and unwise to cut funds in a program that ultimately produces savings to the government in terms of both construction and health care costs.

Mr. Chairman, earlier in my testimony I discussed aging veterans and the demands they will place on the system. In our view, the VA is faced with a second "aging challenge," that of its medical care facilities.

The DAV has always been supportive of the VA's medical construction program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classified as severe under-funding over a long period of time.

The average age, from the original construction date, of all VA medical centers is 45.2 years; 65 medical centers are 50 years old or older; and nine VA medical centers saw their original construction during the 1800's.

Mr. Chairman, this budget request does not go far enough to allow the VA to accomplish what it must accomplish if the system--which represents a multi-billion dollar investment on the part of the American taxpayer--is to remain viable.

As veterans grow older, their need for medical care becomes greater, more frequent and the complexities of treatment grow more costly. Likewise, the condition of VA health care facilities cannot escape unscathed from the effects of age.

Mr. Chairman, the VA is now proceeding with a capital facilities study at 130 of its VA medical centers which will assess each existing building (and system within each building) to determine the overall physical condition of the facility.

This study should yield results identifying deficiencies that require immediate correction, as well as establish long term plans pertaining to the medical construction program.

Mr. Chairman, the DAV supports this major undertaking and we urge the VA to proceed as quickly as possible to complete this vital study.

As you are well aware, Mr. Chairman, there has been considerable Congressional concern voiced over the VA's process of prioritizing major construction projects. As a result, via the 1985 appropriation process, the VA was directed to develop a new and meaningful prioritization process which is to be presented to Congress in March, 1985.

As we understand it, the objectives of the stated methodology would:

- develop an improved method of providing a rank ordering of projects;
- be quantifiable, to the fullest extent practical;
- be responsive to goals, objectives and areas of emphasis; and
- be reasonable and understandable.

Additionally, the new methodology would:

- establish a score for each project using a scoring methodology developed for each category of project, i.e., nursing home, clinical, fire/safety; and
- establish a final project score by applying programmatic emphasis weights. This would be designed to give emphasis to certain kinds of projects based on the VA's belief in the relative importance of one type of construction project versus another.

Mr. Chairman, we cannot endorse the prioritization method prior to a thorough review. However, the DAV certainly supports this concept in theory. By establishing a methodology to prioritize and give emphasis to certain kinds of projects, i.e., nursing homes, clinical, fire/safety, renovations, etc., which are felt to be of relative importance over other projects, the needs of veteran beneficiaries will, in our view, be best served.

Mr. Chairman, we are pleased that the VA is developing a prototype nursing home design that can be adapted to different terrain across the country and ensure uniformity, as well as reduce the cost of nursing home construction.

It is our understanding that the basic floor design--and, where appropriate, the capability for expansion--will be used in common, regardless of where a nursing home might be built and will still allow for certain necessary variables.

Desirable features of this approach include a significant cost avoidance per project of an estimated $379,000, as well as a considerable shortening of the time period from the project identification to the construction award (from 53 months to approximately 24 months).

Mr. Chairman, by the year 2000, the VA's program of institutional extended care for aged veterans which involves VA, state and community resources, will be severely challenged with a projected need to care for 95,000 to 125,000 veterans each day, compared to 40,000 each day in 1985.

The general rule is that 40% of VA supported nursing home bed levels be VA owned and operated, 40% community owned and 20% be in state homes. At this time, we raise the question in conjunction with the aging plan: is too much reliance being placed on the use of community nursing home facilities?

We are concerned that, to our knowledge, no solid verifiable studies have been completed on the extent of the expected excess, if any, of private sector nursing homes to meet the needs of the older veteran population.

This fact, Mr. Chairman, coupled with the moratorium on construction of additional community nursing home beds now imposed by 40 states, places the private sector's ability to accommodate veterans' needs in suspect.

Therefore, we urge the VA and this Committee to donate considerable attention to the question of the VA's extended care needs and capabilities as it coincides with the overall construction budget.

Mr. Chairman, the final point we would like to address is the concept of acquiring additional hospital/nursing home care beds through the process of purchasing already existing medical facilities from the private/public sector.

We are aware of the existence of medical facilities that are currently available for purchase for various reasons. While we do not advocate the arbitrary wholesale purchase by the VA of existing facilities, we do embrace, in theory, the concept of VA acquisition of properties when it is documented that a need exists in a particular area in order to best meet the needs of the veteran population.

Mr. Chairman, this seems to be a viable and cost effective way to add badly needed beds to the VA system at a cost generally far below that of new construction and we would urge the VA to exercise its authority to do so when the opportunity presents itself and is justified.

Mr. Chairman, this completes my testimony and once again I want to thank you for allowing us this opportunity to present our views on this most important subject.

Mr. **Principi.** Mr. Moran, would you like to proceed?

Mr. **Moran.** Thank you. I will summarize from my written testimony.

Mr. Principi, I would like to thank you for the opportunity to speak here today on behalf of our members. I am Bob Moran, associate legislative director of Paralyzed Veterans of America.

PVA is grateful to the committee for conducting this oversight hearing which we believe clearly demonstrates the committee's continuing concern for the current and future health-care needs of our Nation's veterans. All of PVA's members are catastrophically disabled veterans who have experienced spinal cord injury or dysfunction and have considerable contact with the VA health-care system.

The VA's fiscal year 1986 construction budget indicates that the administration is not recognizing the importance of maintaining and building adequate facilities if the VA is to perform its assigned functions. The failure to construct needed VA medical and health-care facilities has been one of the most troublesome veterans' issue for quite some time. By construction, PVA means both the building of needed new facilities and the maintaining of existing ones.

PVA recommends that the VA be tasked with providing a report to Congress before the next budget submission that establishes a bed sizing model which addresses the future needs of all eligible veterans, and that this model must be applied consistently for new construction as well as conversion or closure of existing facilities.

We also have concern for the VA's medical district initiated planning process because PVA finds that the spinal cord injury service does not fit into this planning process. Some medical districts are planning to include SCI centers into their overall construction plan, but there appears to be poor coordination between medical planning districts as to the needs of the SCI veterans.

Currently, the Dallas and San Antonio, TX, catchment areas are treating very large numbers of identified SCI patients. The continued migration by the SCI veterans to the southern climate has placed an even greater need for expansion of SCI facilities within the State of Florida.

Lastly, Albuquerque, NM, is a perfect example of a geographic area in need of SCI services where construction is taking place, that a facility is available for conversion at a minimal cost.

Another program PVA believes would be cost effective is a mobile SCI team which would provide SCI services to veterans utilizing the VA's or the DOD's vast medical facilities. It must be remembered that spinal cord injury is not the only cause of paralysis. It can also occur as a result of heart attack, stroke, and head trauma.

PVA maintains that in most instances the proper care necessary for rehabilitating a veteran back into the community can better be facilitated by the medical center staff having an improved knowledge of all ramifications of paralysis.

In conclusion, PVA is aware that this is a time of challenge to spend Government funds as efficiently and as effectively as possible; therefore, our proposals, collectively, are to improve veterans programs and at the same time be cost effective where possible.

This concludes my testimony. I would be glad to respond to any questions.

Chairman **Murkowski** [presiding]. Thank you, Mr. Moran.

Mr. **Moran**. Thank you.

Chairman **Murkowski**. I do apologize to you and Mr. Gorman for having to step outside. I know that your testimony was taken by the professional staff.

[The prepared statement of Bob Moran, associate legislative director, Paralyzed Veterans of America, and the PVA's response to a written question submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

PREPARED STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the Committee, it is a privilege for me to speak here today on behalf of the members of Paralyzed Veterans of America.

PVA is grateful to the Committee for conducting this oversight hearing, which we believe clearly demonstrates the Committee's continuing concern for the current and future health care needs of our nation's veterans.

As you know, all of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and these veterans have considerable contact with the VA Health Care System and the facilities in which the VA extends medical and health care services.

This year's FY'86 budget process included a new twist. Recommendations by the Office of Management and Budget for drastic cuts in domestic programs were presented to the President and to the public prior to each respective federal agency being able to do a final review and rebuttal. This technique was designed to arouse the public's interest early on in the budget development, and created the most vocal protests from those who truly understand the devastating impact of further cuts in federal health care programs. Their concern, however, is currently without popular support. The public is preoccupied with rising health care costs, but generally lacks the understanding of the causes.

The emphasis, unfortunately, in this complex issue has shifted totally from the recognition that as a nation we have been successful in building the world's best health care system, which provides access to quality health care to all sectors of our population, to one that focuses exclusively on the cost factor. While disregarding that such medical care elements as human concern, compassion, and social responsibility simply do not translate in economic values.

The debate regarding the restructuring of the nation's health care programs, including the VA, will continue as the Administration proposes budget cuts throughout the various programs within the federal government. During the past few years Congress has reduced the projected Medicare/Medicaid expenditures by some $18 billion dollars. The President has proposed additional cuts in Medicare and Medicaid of $5.9 billion in FY'86 and $27.1 billion by FY'88. Included are reductions in Medicare reimbursement for capital expenditures; a fifty percent reduction in Medicare indirect subsidy for medical residency education and severe cuts in federal support for medical education loans and scholarships.

In light of these budget cuts for FY'86 and the coming years, within the private sector, these proposals take on a significant importance to veterans because of the potential impact upon the VA Health Care System. The fact and future of the VA and private sector medical systems are inextricably linked. One third of all veterans over the age of sixty-five are medically indigent, which may explain why the VA medical system is proving to be a demonstrable safety net for veterans who can no longer afford the increased co-payments of Medicare.

The huge task today of caring for these veterans cannot be left to state and local governments which are not equipped for such an effort, and already overburdened. The cost of providing for our nation's veterans is an obligation that is associated with the continuing cost of our National defense.

The VA Healthcare System

Historically, this country has cared for its veterans. It was in his second inaugural address in March 1865 that President Abraham Lincoln called upon Congress and the American people "to care for him who shall have borne the battle and for his widow, and his orphan." This has become the motto of the VA.

The VA's Department of Medicine and Surgery is the nation's largest integrated comprehensive system. It is the only system providing a full continuum of health care to veterans made eligible for care on the basis of laws passed by Congress and signed by the President. From its research laboratories have come tremendous contributions to medical knowledge. The VA is also the nation's single largest health manpower production resource and, as a key element in national security, the principal on-line contingency backup to military medicine. It is a system clearly worth saving. It is, in fact, a model for the nation, a harbinger of things to come. Its integrated, comprehensive provision of service is a blueprint for the vertical and horizontal integration now underway in the private sector's effort to adjust to the competitive medical market.

Up front should be an appreciation that the VA has an exemplary record in cost containment. There has been no growth in terms of inflation corrected constant dollars in its annual medical care budget for the past ten years. During this time the annual inflation rate for the Medical Care Price Index averaged twelve percent while the yearly VA medical operating costs increased by seven percent. The FY'75 VA medical care budget figure was $3.7 billion and in FY'85, $3.6 billion in constant 1975 dollars.

During this decade of straight line budgeting there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one third and the total annual patient work load increased by thirty percent. Annual out patient visits increased by two million. An additional 3,723 nursing home beds and sixteen out-patient clinics were added to the system and 136 new Vet Centers provided readjustment counseling to over 300,000 Vietnam Era veterans. During the same period sixteen thousand VA hospital beds were closed.

In light of the progress made in the VA health care system in terms of efficiency and the increasing demand being placed upon it, it it most disturbing to PVA that the Fiscal Year 1986 budget proposal contains provisions which can only be detrimental to the VA and the veterans it serves.

FY'86 budget decrements for the VA Department of Medicine and Surgery are, in many ways, reflective of options under continued study by the White House Office of Policy and Planning. These options have been identified in the recent Congressional Budget Office report on "VA Health: Planning for Future Years," the notoriously flawed Grace Commission Report, and by the Office of Management and Budget itself.

It is unlikely that the VA health care system could be dismantled by fiat, but there is clear and present danger that full implementation of certain of these options would be tantamount to its destruction. Unfortunately, the purpose, the nature, and the value of the system as a national resource is little known and even less understood by the public. Only with such understanding can the impact of certain policy proposals targeting veterans medical care be measured.

The Aging Veteran Population

The Administration makes it quite clear its imperviousness to any understanding of the medical needs of the aging American, let alone the aging veteran. The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking very seriously. After more than a year of demographic analysis, discussion and review by outside consultants, it published in mid-1984 a comprehensive report "Caring for the Aging Veteran." The veracity of this report was further supported by a Lou Harris survey and contracted studies by Harvard University's Division of Health Policy Research and Education. A simultaneous report from the Congressional Budget Office concurred with the data obtained from the VA's demographic survey.

The VA plan provided a detailed overview, based on projected need, of the opportunities presented by the aging of its constituents. Whereas three million veterans today are over age 65, by the year 2000 that number will triple to nine million or 36 percent of all veterans. In 1983 some 800,000 of the three million veterans over age sixty-five came to the VA for one form of care or another. That represents over twenty-five percent of all veterans in that age group. And one half of them had never previously made use of the VA health care system.

Because it is dealing with a population whose average age is increasing much faster than that of the general population, the VA's accommodation to this impact could serve as a proving ground for private sector programs to follow. To maintain current levels of care the nation's elderly will, by the year 2000, occupy all of today's empty hospital beds and require a fifty percent increase in present nursing home facilities. In more dramatic terms, tomorrow's elderly will require the opening of one hundred nursing home beds every day for the next fifteen years. Today, the VA alone supports an average census of twenty five thousand veterans in nursing homes, sixty percent of whom are in community nursing homes. This need will double by 1995.

The main emphasis in expanding VA geriatric capability, was to be placed on noninstitutional care programs such as outreach satellite clinics, adult day care centers and rehabilitation units, hospital-based home care and hospices. The VA had intended to seek legislation in this area for increased sharing and coordination with the private sector. The goal was to exert maximum effort to integrate VA programs for the elderly with similar programs in the community at large.

In spite of these well-documented requirements, little program enhancement resources appear in the proposed coming year budget or in its out year projections. In contrast, the Office of Management and Budget budget guidance contains the words "shrink the VA system size gradually." Blocking the development of geriatric program alternatives to institutionalized care will have a stultifying effect on the VA's system, and will itself add to overall costs and, in turn, drastically retard the nation's preparedness to meet the medical and socioeconomic needs of its aging citizens.

VA Construction - Adequate Planning

The VA's Fiscal Year 1986 proposed construction budget of $611.6 million in new budget authority indicates that the Administration is not recognizing the importance of maintaining and building adequate facilities, if the VA is to perform its assigned functions. This is particularly true regarding the emphasis on construction of new nursing home facilities, which is even more evident when keeping in mind the staggering figures needed as mentioned earlier.

It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require over a one billion dollar (in constant 1985 dollars) construction budget for the next ten years. Implication of intended future policy is also to be found in the Fiscal Year 1986 guidance that construction projects in the out years should be sized solely upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120 bed facilities in Fiscal Year 1986, a reduction of 720 beds from the level requested. PVA was disturbed to see the failure of the majorities recommendations, in regards to the budget, to specify the needed progress within the VA's construction program, when considering the ever increasing demand that will be placed upon the VA's health care system. Likewise, we oppose the minorities position and recommendations that no VA medical facility be constructed with over 700 hospital beds. PVA contends that the bedsizing criteria should first be developed, and that then based upon the veteran demographics, the VA medical facility be built with the adequate amount of hospital beds to most effectively serve its veterans.

The needs of the aging veteran population will continue, as mentioned earlier, to place this ever-growing demand on the VA's health care delivery system, and it is extremely important that adequate physical facilities be developed and maintained.

The Fiscal Year 1986 budget for VA construction is not a positive sign, and it raises several questions. The failure to construct needed VA medical and health care facilities has been one of the most troublesome veterans' issues for quite some time: by "construction" PVA means both the building of needed new facilities and the maintaining of existing ones. It is a very serious matter that so many VA facilities are now in a state of decay. Some are only marginally meeting the needs of the veterans who use them. The Department of Medicine and Surgery (DM&S) has testified before this very Committee, that as of 1983, over 50 percent of its authorized beds where located in buildings that were over thirty years old. Decaying facilities not only hamper patient usage of some VA medical facilities, but their poor condition makes it doubly difficult to recruit and retain qualified staff.

PVA recommends that the VA be tasked with providing a report to Congress before the next budget submission that establishes a bed sizing model which addresses the future needs of all veterans. This model must be applied consistently for new construction, as well as, conversion or closure of existing facilities. The reliance on the use of Diagnosis Related Groups (DRG's) is inappropriate for such a model due to their newness and their failure to cover a significant number of conditions or multiple conditions being treated by the VA today.

SCI - Adequate Planning

While the VA's current management practice used to identify medical facilities needs, Medical District Initiated Planning Process (MEDIPP), assists in formulating construction plans at the district level, PVA finds that the Spinal Cord Injury (SCI) service, which is of the utmost importance to PVA, being a rather unique service within the VA, does not fit into this planning process. We are pleased to be working with the VA Central Office to overcome this shortcoming by providing data on potential sites for needed SCI

Centers, and, in a letter dated March 8, 1985, to VA Administrator Walters we again provided our position and comment on the desirability of certain locations for new SCI Centers. Hopefully, this information is proving useful to the more localized efforts of MEDIPP.

One concern we wish to express with regard in the current MEDIPP procedure is the lack of a yearly carry-over of approved construction projects. In addition, we are finding that some medical districts are planning to include SCI Centers into their overall construction plan, but there appears to be poor coordination between medical planning districts as to the needs of SCI veterans. The problem then becomes, who within the VA speaks to the needs of the spinal cord injured veteran. Hopefully, this situation will be rectified while PVA continues to monitor these needs, and we continue to investigate potential new sites for SCI Centers.

The VA has prepared two comprehensive studies of SCI veterans and an analysis of the demands they will make on the VA health care system. These studies are entitled, "The Spinal Cord Injury Program Plan: FY 1980--1987" and "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1984--1990." The first noted study is a broad analysis of the VA's SCI program (to include staffing needs, medical specialties required, and other appropriate health care matters), and at the very core of the study is the assumption that VA SCI Centers will be placed where needed in order to better serve SCI veterans.

In this regard we request the VA to continue to take the following factors into consideration when selecting the site for an SCI Center: 1) availability of a suitable existing structure readily accessible in terms of geographical and transportational facilities; 2) strong affiliation with a medical school; and 3) proficiency of medical staff in the disciplines critical to spinal cord injury care and research.

With all of this in mind, PVA suggests the following sites for new or expanded SCI Centers, which veteran demographics and related VAMC admissions and treatment statistics support that these areas are the most urgently in need of an SCI facility, they are: Dallas or San Antonio, Texas; Florida; and Albuquerque, New Mexico.

Statistics indicate that the Dallas and San Antonio catchment areas are treating approximately 2,000 identified SCI patients. In the best interest of SCI veterans, ideally both locations could support an SCI facility but PVA would recommend that if funds dictate, that only one or the other site receive funding for SCI construction. In addition, the continued migration by the SCI veteran to the Southern climate has placed an even greater need for expansion of SCI facilities within the State of Florida. And lastly, Albuquerque is a perfect example of a geographic area with veterans in need of SCI services, where construction is taking place and that a facility is available for conversion at a minimal cost.

In 1980, the VA had 1,365 SCI beds, which is about the same number as exists today, five years later. Even though Centers have been added to the SCI Service, the size of existing facilities has been reduced, and entire SCI wards have been closed. At the time of its study, however, the VA estimated that by Fiscal Year 1985, 1,845 beds as a minimum would be needed in the SCI service.

Given a situation whereby all existing SCI veterans would require routine hospital services in a given year, the VA estimated that 6,439 SCI beds would be needed. PVA maintains that an accurate figure of SCI beds needed is somewhere between these two estimates (1,845 to 6,439). Either way, it is clear that increased SCI services and beds are needed.

When emergency situations develop, or when routine checkups are needed, SCI beds are too often already filled. Because of the bed shortage, emergency admissions mean that first, lower priority care patients must be moved about, and second, SCI veterans who have examinations scheduled must be abruptly notified of cancellation and rescheduling. This can be especially frustrating for catastrophically disabled veterans who have special travel considerations which must be arranged in advance. Also, the problem is further aggravated when SCI veterans must travel long distances, as is often the case in states where populations are dispersed over great geographic distances.

The Aging SCI Veteran

The request for improved and expanded care for aging veterans has been expressed by all veterans' service organizations, the Congress, members of the Administration, and our society in general. The questions of future funding of VA construction projects and the ability to provide the best possible health-care services to aging veterans are closely related.

Many of PVA's and the VA's cooperative endeavors have included consideration of programs for our aging veteran population. Many of our common hopes, however, have been greatly diminished by the quick stroke of a pen with the President's budget proposal that reduces funding for these VA programs. The reduced budget virtually nullifies the productive efforts of the VA to examine and provide for the needs of the aging veteran population.

As the aging veteran population grows, so will their need for health care; everyone, but the Administration, seems to know and realize this fact. The questions remain - how and when will this Administration, or for that matter any administration, begin to take into account and make preparation for the needs of aging veterans, including aging SCI veterans?

The aging spinal cord injured veterans are a relatively new medical phenomenon, and very little has been done by the VA to plan or provide for the special needs of these veterans. The increasing number of older SCI veterans, and their changing health care requirements and the continued migration (as mentioned earlier) to the Sunbelt States require prompt action by the VA to provide for these veterans' special health-care needs.

PVA and the VA are now working together in an effort to address this problem of providing adequate facilities for aging SCI veterans. While current VA standards for nursing home construction have not addressed the broad requirements for wheelchair accessibility, tangible progress is being made to accommodate the aging SCI veteran. In addition, as the VA continues to develop its prototype nursing home plan, design features for SCI veterans will be incorporated into the final program.

In addition, PVA requests the VA to examine those viable alternatives to institutional care that are currently being administered within the VA and in the private sector. We refer to programs such as hospital-based home care, respite care and adult day care programs. For PVA's members and other chronically disabled individuals, institutional care is neither desired or required in most cases. In fact, for most forms of long-term illness or injury, in-home programs of health-care are proving themselves to be not only cost-effective but much better emotionally for the disabled individual.

Hospital Based Home Care

Hospital-Based Home Care (HBHC), is presently being conducted within 49 VA Medical Centers and within 18 of the 19 Spinal Cord Injury Centers. The purpose of HBHC is to provide hospital-based home care for short periods of time and to help provide transition into the community environment thereby reducing hospital costs. This program is primarily provided the disabled person who is in the final stages of convalescence and/or rehabilitation.

PVA is very concerned that the Fiscal Year 1986 budget for the SCI/HBHC program remains unchanged, whereas the overall HBHC budget provides for an increase of six new HBHC programs, an increase of 18 FTEEs and a $670,000 increase in funding.

Last year, the VA reported that a total of 19,301 home visits were made to 2,189 catastrophically disabled veterans in the SCI/HBHC program alone. It is our belief that the SCI/HBHC program has demonstrated its effectiveness as a viable program and is worthy of increased funding consideration.

Respite Care

Realizing full well the ever-increasing costs associated with hospital based health-care, especially for the chronically-ill or long-term disabled, alternatives to institutional care need to be developed. PVA, based upon its own knowledge of the subject and by research done into the role of the "significant other," as it portends for the aging SCI veteran, strongly supports the implementation of a VA sponsored respite care program. Respite care is a concept that provides short term relief from the responsibilities of caring for a chronically ill or disabled family member, while helping to maintain family equilibrium. Respite care programs serve elderly or impaired individuals who want to remain at home, and care givers who want to care for the relative or spouse at home.

PVA recommends a VA respite care program that offers assistance not only to the aging veteran, but also to the catastrophically disabled veterans, regardless of age. We believe respite care programs that serve the chronically disabled can be cost effective while serving the needs of the provider, the consumer, and the care giver.

Last year in testimony before Congress, Dr. George Hohmann, Ph.D., expressed concern for the aging SCI veterans who seek assistance in the home or dormitory home to alleviate the need for admittance to VA medical centers and nursing homes. A respite care program is very much needed for the SCI veteran attempting to return to and maintain personal residency in the home environment.

To maintain the SCI veteran in the home dictates providing support services to both the veteran and his family care givers. Respite care programs are ideal in that they are designed to relieve the emotional and physical stresses of both the SCI veteran and his spouse or "signficant others" who provide the needed care. The program we advocate would provide carefully trained people to go into the home, to allow the "signficant other" the opportunity to take care of business, the shopping, errands, or simply time for themselves, relieving them temporarily from the burden of providing long term care. Respite care is also necessary when the "significant other," be it a spouse or family member, suffers a personal injury or illness.

A respite care program will offer health care in the home environment in lieu of an institutional setting. Realizing the ever-increasing cost associated with care provided in a hospital or in a nursing home, respite care can prove to be very cost effective. For example, the cost of providing three hours of care daily, by a licensed practioner in the home, is considerably less than the cost of three hours of any service provided by a hospital or nursing home, if such services were available.

The requirement for the VA Administrator to report to Congress on respite care is a needed and overdue action. Hopefully, the report of the Administrator will address the need for respite care to help alleviate the psychological burdens placed on family members. Often the day-to-day care provided by a family member is overlooked even though it is essential in precluding a veteran's institutionalization.

Mobile SCI Care

Another program PVA believes would be cost effective, which would provide SCI services to veterans utilizing the VA's and DOD vast medical facilities, is a Mobile SCI Team. A continuing concern of PVA is the need for more convenience in obtaining routine medical services. There are presently nineteen medical centers which have specially designed units trained to deal with the problems of spinal cord injury. Personnel at these centers are versed in intensive rehabilitation, sustaining care, and/or long-term care. We are proud of these units and the specialized care they are able to provide. The concern that we have is that aside from these nineteen centers, the other VA medical centers and VA outpatient clinics do not have the necessary expertise to deal with many of the routine practices as performed in the SCI Centers.

PVA realizes that the number of veterans who have experienced spinal cord injury or dysfunction is not large enough to warrant special SCI units in every VA hospital or outpatient clinic; however, the idea of SCI Center personnel utilizing VA medical centers, outpatient clinics, and Department of Defense military hospitals where no SCI unit exists is warranted. This facility sharing would broaden the base for veterans to receive routine physical exam work which may be a realistic and cost-effective alternative for all concerned. The value of such an idea becomes evident after examining the two systems, which includes 172 VAMCs, 226 VA outpatient clinics, 131 DOD military hospitals, nationwide, and the 168 military hospitals DOD has worldwide.

A "traveling team" of SCI trained specialists would be able to utilize the medical equipment available at each VAMC, outpatient clinic, or DOD facility. In addition, the opportunity for SCI trained professionals to interact with other medical professionals in providing care to SCI veterans, would prove beneficial to those health-care professionals who may work with other paralyzed veterans in the future.

Under PVA's proposal, the SCI veteran could be provided close-to-home treatment, thereby reducing the cost of beneficiary travel. The veteran could also be provided preventative evaluations which would result in fewer inpatient visits since problems would be detected earlier. Furthermore, if hospitalization were required, the stay would be shortened, because many of the preliminary tests would have already been performed.

It must be remembered that spinal cord injury is not the only cause of paralysis; it can also occur as a result of heart attack, stroke, and head trauma. Veterans incurring paralysis from these causes are generally treated in regular VA medical centers. PVA maintains that in most instances the proper care necessary for rehabilitating the veteran back into the community can be better facilitated by VAMC staff having an improved knowledge of all the ramifications of paralysis. We think this knowledge exchange could be accomplished by the SCI "traveling team" concept, and we would encourage the Congress and the VA to consider the positive implications of such a plan.

Conclusion

Mr. Chairman and Members of the Committee, PVA is aware that this is a time of challenge and we are concerned about the American taxpayer and the need to spend government funds as efficiently and as effectively as possible; therefore, our proposals, collectively, are to improve veterans programs and at the same time be cost-effective where possible.

We understand you face the adversity of limited resources, but remember, that VA benefits and the programs we discussed here today were earned in adversity. Integrity, honesty and constancy of both individuals and nations, are and always have been, tested in times of adversity, not times of plenty and of ease. The problems confronting us are a challenge to all of us and yet it is essential that we pass the test.

Mr. Chairman, and members of the Committee, I again thank you for the privilege of appearing today. I have discussed numerous concerns and hope I have let some insightfulness here today. This concludes my statement, and I will be glad to respond to any questions that you might have.

RESPONSE OF THE PARALYZED VETERANS OF AMERICA TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question.

Please describe the extent to which the current VA NHCU standards provide for wheelchair accessibility and the manner in which and extent to which the VA prototype for nursing-home-care construction will do so.

Answer.

The VA's current standards used in the planning and construction of nursing-home-care units and the prototype nursing home do address the issue and provide for the basic requirements (no steps, extra-wide hallways/doorways) for wheelchair accessibility. But, the fact remains that very little has been done by the VA to plan or provide for the special needs of the aging spinal cord injured patients within these facilities.

The aging spinal cord injured veterans are a relatively new medical phenomenon, which is due to the medical advancements that allow greater freedom and longer more productive lives, and it is these very same veterans that pose a significant problem to the VA.

SCI veterans differ drastically from that of the non-SCI veteran, (which warrants changes in planning and construction of VA facilities) in various ways. The SCI veteran for the most part is younger than that of the regular geriatric patient. With this difference of age, all too often comes years of experience in being disabled and the expertise associated with mobility, being wheelchairs and gurneys.

It is these modes of mobility used by the SCI veteran that pose the even greater need for adequate planning and construction. The current standards of extra-wide hallways and doorways take on a whole new meaning.

PVA is pleased to be currently working with VACO in developing its prototype nursing home plan and in specifically addressing and incorporating into the design features those special requirements needed by the SCI patient.

Being incorporated within the VA's prototype nursing home are two, two SCI bedrooms per 60 bed nursing-home-care units. These rooms located at the end of a wing or corridor, allow for the added square footage needed for mobility by wheelchairs or gurneys.

Treatment of certain medical phenomenon unique to SCI medical conditions, such as skin breakdown or decubitus ulcers, urinary tract infections, and possible upper respiratory infections, warrant these special space requirements.

For example, a SCI veteran who incurs a massive skin breakdown in the buttocks area, may have to spend months laying face down in a prone position on a gurney. Restrooms have to be specially designed to allow movement and in having the necessary facilities needed by these patients. It is this type of situation which is common among SCI patients that necessitate these special requirements within a facility, that is even greater than that of a nursing home.

PVA, being comprised solely of spinal cord injured veterans, will continue to monitor and work with the VA in planning and providing adequate SCI facilities for veterans in the most efficient and cost-effective manner.

I hope this answers your specific quescion in regards to the extent in which the VA's prototype nursing home construction provides for accessibility and thank you for your input and concern into the issue of adequate planning and construction by the VA to care for our nation's veterans.

Chairman **Murkowski**. We have discussed a good deal already about the age of the current hospitals. I am told that about half are 40 years old, 80 percent older than 30 years old. With this age limitation and given the limitation of time and resources, do you have any comments as to the 10 construction projects we have before us. More specifically, the ones that we have programmed within the proposed fiscal 1986 budget involves Houston, Mountain Home, and Philadelphia, which will receive the bulk of its funding in the future. Augusta, GA, is planned for the future and Baltimore after that. So we really just have two. We have Houston and Mountain Home.

Mr. **Moran**. Yes. Well, in regards to specific projects as far as the 10, we feel talking possibly about Baltimore, where money is expended to start a facility, that once it is started, if the priority process worked and worked effectively, where moneys were allocated and being spent for acquisition of land, if the priority system had worked where projects weren't started and then held up, that we would be spending our money as effectively as possible.

As far as Houston, it has been number one, two or three on the list and money has been allocated and it has been started. I think estimates indicate that if the project is held up or possibly downsized that it is going to cost a significant amount of money. I don't think we want to see this where moneys have been allocated and a project is started then stopped, which is a waste of money.

Mr. **Gorman**. From the DAV's viewpoint, Mr. Chairman, I would say that, without getting into the specific projects that are either planned or in the pipeline right now, our primary concern, and I think it should be the concern of everybody, is specifically the size of a specific VA medical center should be based on the documented needs of the veterans in that geographic area.

I would agree and we would agree with a statement that Senator Simpson related to this morning or made this morning that we do not advocate the VA going out and building any Taj Mahals as far as a hospital. We think they should, again, serve the veterans' needs in that area and be functional.

Chairman **Murkowski**. Do you have any opinions as to the year-old evaluation of the Houston facility?

Mr. **Gorman**. Not specifically, Mr. Chairman, I do not.

Chairman **Murkowski**. Do you think it is appropriate that you do?

Mr. **Gorman**. No. I think our statement is appropriate that as long as the hospital that is in Houston or in any other location meets the needs of the veteran population in that area, that is what we are concerned with.

Chairman **Murkowski**. Well, you know, we are not all from Houston, not that that is relative to what our true needs are. But you know this has been labeled a Taj Mahal by responsible people.

Mr. **Gorman**. I have not had the opportunity to see either the physical hospital——

Chairman **Murkowski**. I have not either. But I am asking you——

Mr. **Gorman** [continuing]. Or the blueprints.

Chairman MURKOWSKI [continuing]. As a representative of your organization whether you think it is appropriate that you address whether, in your opinion, it is or is not a Taj Mahal?

Mr. GORMAN. I said I do not think it is appropriate that the VA should be going out and architecturally designing and building Taj Mahals.

Chairman MURKOWSKI. I agree with that.

Mr. GORMAN. My opinion is that they should be constructing a functional VA medical facility——

Chairman MURKOWSKI. I agree with that.

Mr. GORMAN [continuing]. Whether it be a hospital or whether it be an outpatient clinic or a nursing home.

Chairman MURKOWSKI. Do you feel that your organization should have any role in commenting whether it is a Taj Mahal or not?

Mr. GORMAN. The Houston Facility?

Chairman MURKOWSKI. Yes.

Mr. GORMAN. I do not believe anybody from our organization has seen physically the Houston facility or any of the drawings for the use of the facility. I do not think we could comment on that.

Chairman MURKOWSKI. Would you like to be furnished with that information?

Mr. GORMAN. What information specifically, Mr. Chairman?

Chairman MURKOWSKI. The drawings, the layout, and the comparison?

Mr. GORMAN. Well, I would see no problem being furnished with it and reviewing it, with the caveat that we are certainly no experts in engineering or architectural work.

Chairman MURKOWSKI. Well, neither are we.

Mr. GORMAN. Sure. We would be more than happy to take a look at it.

Chairman MURKOWSKI. Well, if you would like it we will give them to you. What we are asking is for somebody out there representing the veterans to say there is a better way to provide needed service.

Mr. GORMAN. In my comments I related to the fact that although we cannot endorse it because we have not seen it—I do not know if the committee has seen either—the VA's prioritization plan. We do in concept and in theory support a defined methodology that will in the future be able to prioritize one type of a project or a category of projects over one another as far as need.

Chairman MURKOWSKI. Will your group be with us tomorrow?

Mr. MORAN. Yes.

Chairman MURKOWSKI. Will representatives of the DAV be here?

Mr. GORMAN. We will be here, yes.

Chairman MURKOWSKI. Because I understand the Hospital Corporation of America is going to testify tomorrow. There have been statements made by private sector hospital associations that indicate that they can, as compared with VA, build facilities in half the time for half the money.

Would you support that application, if indeed the quality of the facility is appropriate to service the needs of the veteran?

Mr. GORMAN. Are you asking whether we would support the private contracting of a——

Chairman **Murkowski**. No. I am asking you if you would support the concept of planning as proposed by the private sector, who claims that they can build a facility in half the time for half the amount and still provide a facility capable of giving quality care?

Mr. **Gorman**. I think, first of all, there are variables involved in private contracting versus VA contracting. The first, and probably foremost, is that of the VA's policy of building on the existing campus of a VA medical center. I do not know what the private contractors claims to be. I would be inclined, however, to hear their testimony tomorrow. If there is any further comment, we could make it at that time.

Chairman **Murkowski**. I would appreciate your evaluation of that testimony.

Mr. **Gorman**. We would be happy to provide it.

Chairman **Murkowski**. If you have any questions that you would like asked, I would be willing to take your questions, even though it is a departure from procedure. I would have to identify them, however. Is there a potential savings to be realized from changing the process in which the Veterans' Administration builds hospitals? Do not misunderstand me, I am not suggesting that we have the private sector build the hospitals or operate them. I am talking about a procedure. I have observed, as you have, generally speaking that the Government process is not the most efficient in the world because it does not have to be. That is why I would particularly welcome the comments of the members of the Veterans of Foreign Wars who indicated their willingness to support the idea of examining both issues, the private sector vis-a-vis the public sector to determine once and for all—and that may be wishful thinking—how the Government could get the greatest return for its investment and obligations.

So I would offer you that opportunity if you have any questions as a consequence of the testimony tomorrow. I would be pleased to ask those on your behalf.

Mr. **Gorman**. I want to assure you, Mr. Chairman, the DAV also shares your concern that the VA does get the best bang for its buck in their various programs, most assuredly.

Chairman **Murkowski**. Thank you. I want to thank you as witnesses for Paralyzed Veterans of America, and for the Disabled American Veterans, Mr. Gorman. I want to thank all of you for participating and establishing a record for this hearing. The record will remain open for how long, a week or 10 days? A week?

Mr. **Principi**. Ten days.

Chairman **Murkowski**. I want to thank Cindy Alpert from our staff for putting this together.

I think we touched on a number of areas that deserve further examination in light. Some of them are a little sensitive. But you know, those are the ones that we need to get into, the sensitive ones. Again, I would reflect on my position that these issues need to be examined and aired so that all doubt, or within a degree of doubt at least, is removed and we are making a judgment based on as much knowledge as we can ascertain.

I guess I feel good about what I perceive is a willingness of the service organizations to be more expressive about the merits of the dilemma that we are in, that it just cannot be expected that we are going to have more in the way of funding, and as a consequence, indeed, we are going to have to seek other alternatives. I was particularly pleased to note that reference in Senator Cranston's opening remarks that indeed the money situation is a very real one, we cannot have the best of both worlds that we would like to have. So it behooves us to look to other alternatives.

I know there is a sensitivity on behalf of some of the service organizations to depart from the norm, but I think it is mandatory that we explore all our alternatives for the obligation that we all have, and that is to provide better service for the veterans of our country.

Thank you very much for being with us.

Mr. **Moran**. Thank you.

Chairman **Murkowski**. The committee is recessed.

[Whereupon, at 12:18 p.m., the committee adjourned, subject to the call of the Chair.]

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OVERSIGHT ON CONSTRUCTION OF VETERANS' ADMINISTRATION MEDICAL FACILITIES

WEDNESDAY, MARCH 27, 1985

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SR-418, Russell Senate Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Chairman Frank H. Murkowski, Senators Jeremiah Denton, and Alan Cranston.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman MURKOWSKI. We will call the committee meeting to order, the full Committee on Veterans' Affairs. I want to indicate that this is the second day of the committee's hearing on VA medical facility construction. Today we will explore certain aspects of the VA's construction process, including planning and execution.

The VA facilities are, of course, designed to meet the highest patient care and engineering standards of our country. The newer facilities take into account the latest in the state-of-the-art in construction and medical technology.

The VA has an extensive construction planning process, as many as 32 departments, I am told, and players, including the various chiefs of staff and the administration play important roles in the complex endeavor. And in the most elaborate cases it would take as much as 8 years from the day the first medical district plan is submitted to the day the facility is occupied.

There is the national firm of Booz-Allen, which is a private consulting firm, conducting an indepth evaluation of the VA's construction planning process.

I would like to take this opportunity to commend the VA Administrator, Harry Walters, for his support in this effort. I look forward to the results of the Booz-Allen study and, hopefully, to an examination, by the VA, of their recommendations. In an era of strong competition for medical resources we must ask, how can the VA distribute its construction resources in the most equitable manner to benefit as many veterans as possible. I am most concerned about veterans who live in areas where there are no VA hospitals or other sources of health care.

I guess the specific question is can the VA improve its methods in order to size facilities in direct proportion to the needs of veterans in those areas. If so, I believe we can improve access to healthcare services for veterans who live in areas with an insufficient number of VA or other hospital beds.

Dave Gorman, of the Disabled American Veterans, stated in yesterday's hearing that the VA hospitals which are designed as architectural marvels are not necessary to adequately meet the goal of quality patient care.

I agree that their view is an accurate one. I believe that members of the committee and veterans' service organizations would be in favor of cost-efficient designs which could be built more quickly and for less money but at the same time not diminish the quality of the care.

Today we will examine some construction planning experiences from the private sector, in order to determine if the VA construction process can be streamlined and fine tuned. This exploration is not meant to single out the Houston project or any other proposed replacement hospital. It is not our intent to embrace new and different recommendations just because they may differ from the VA's current practice. However, we must expand the dialog regarding VA construction planning in order to get a firm grasp on where we are now and where we are headed for in the future.

I would like to place in the record at this point a written statement submitted by Senator Rudy Boschwitz.

[The prepared statement of Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota, follows:]

PREPARED STATEMENT OF HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Mr. Chairman, I want to commend you for your decision to hold two days of hearings on the VA's medical construction process. Having battled the process myself in the construction of the Minneapolis replacement facility, I have nothing but sympathy for others trying to understand the VA's methods.

I want to especially commend you for bringing in witnesses from the private sector and giving us the opportunity, on the record, to see how the VA's costs compare. Clearly if the VA can show it is comparable, it will make our jobs easier. But if it is true, as most of us suspect, that VA facilities cost more to build and more to run, then we will need to more creatively use our resources.

Mr. Chairman, I have been very interested in health care for the aging veteran -- where will we find the nursing home and acute care beds needed to care for our aging World War II vets; and how do we propose to pay for this care. I strongly believe that we can and will meet our commitment to these veterans. I plan to study the testimony with great care.

In addition, I find the timing of this set of hearings very helpful as I put the final touches on the veterans health care legislation I plan to introduce next week.

Mr. Chairman, attached are several questions I would like submitted for the record.

Chairman Murkowski. I would like to take this opportunity to welcome my colleagues from whom we will receive testimony this morning. At the witness table is Hon. Jerry Denton from the State of Alabama. We are also joined by Hon. Lloyd Bentsen from Texas.

I welcome you gentlemen to the hearing. I look forward to your testimony. We will begin with Senator Denton, who seems to be already warmed up.

As a member of this committee, we welcome you on the other side of the table.

TESTIMONY OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator Denton. Thank you very much, Mr. Chairman.

I am pleased to have this opportunity to testify before you and the committee on an issue that is of great importance, great concern to me as a member of the committee, and, in a particular sense, of great concern to all veterans in my State.

For each of the 4 years that I have been a member of the committee, the VA has requested large sums of money to build new hospitals to serve our veterans. The costs of the new hospitals are substantial, and we see with some frequency the construction of large, modern, expensive facilities in localities where it appears difficult to justify the size and the cost. The example of the new hospital in Houston comes immediately to mind, and I know that several of my colleagues on the committee are concerned about it.

I have taken a quick look at the costs of recently activated VA hospital facilities, and I think that it is interesting. For 10 hospitals activated between 1973 and 1984, ranging in size from 205 beds to 1,305 beds, the costs per bed of the total project, in 1984 dollars, ranged from a low of $95,000 to a high of $313,000. I say again, for each bed in those projects the average price ran from $95,000 a bed to $313,000 a bed. The average cost per bed for the 5,951 beds built with $1,117 million 1984 dollars was about $188,000, in those newly built hospitals.

I must say, Mr. Chairman, that I have not noticed any concrete inclination on the part of the Veterans' Administration to deal with that problem by finding less expensive or more cost-effective ways to provide necessary new or replacement beds. Indeed, the VA takes pride in the fact that it has not in its history acquired existing hospitals, other than its initial taking over of existing military hospitals, and that it builds new facilities of the most modern and, I must say, most expensive kind.

Everyone who has looked at the problem says that, if the VA is going to continue to add hospitals, and I believe it must, it needs to find a less expensive way to do that. The Congressional Budget Office, the Office of Management and Budget, and the VA itself have all said that the VA may well have to, or should, consider the lease or purchase of existing hospital facilities. Yet I have yet to see any action from the VA to explore, much less implement, that concept.

The problem has been brought home to me by a situation in my own State that seems to provide an unexcelled opportunity to save money and still provide excellent services.

As background, it is important to understand that the VA planning process for the medical district that includes Alabama, the Florida Panhandle and southeastern Mississippi has for several years provided for the construction of a new VA hospital, in the early 1990's, to serve the veterans located in the Florida Panhandle, south Alabama, and a small portion of Georgia. The process that produced that plan was mandated by Congress, and the document that lays out the plan is called "The Florida Panhandle Workbook."

We are talking about another expensive new hospital to be located in the panhandle, and at a place, Fort Walton Beach, where there is no medical school with which to establish an affiliation.

It is, therefore, clear that the VA has accepted the need for a new hospital in the region. There may be some question, however, about where to put that new hospital.

Last year, and by coincidence, a very fine private hospital in Mobile, AL—Providence Hospital—became available because its owners and operators, the Sisters of Mercy, are building a new hospital in a different part of Mobile. They are not building a new hospital because there is anything wrong with the old one, large parts of which are new and all of which is well maintained.

They are building because of a perception that their service mission required a different location. Indeed, I have been advised informally that, were the decision being made today instead of several years ago, the Sisters would probably not decide to build a new hospital.

In any case, the die is cast. And the veterans in the area saw the availability of Providence as a boon to address a situation in which it was clear that the VA itself saw the need for a new hospital but in which that new hospital would be many years in the making and cost a great deal of money. They developed the view that the VA, the taxpayers, and the veterans would be better served if the VA acquired Providence as a VA facility rather than building a new hospital.

There were some additional considerations involved in the decision. Providence Hospital is relatively large, with 349 acute care beds, and has an adjacent 126-bed school of nursing which could be used for a veterans' nursing home. There are no nursing home beds currently available in south Alabama. The grounds are about 15.3 acres with 1,000 paved parking spaces. There is a residence with space to house 13 employees.

The hospital has the most modern facilities and equipment, all of which are available for purchase. In addition, the hospital could easily be a very good tertiary care facility because of its existing capabilities and the possibility of affiliating with a good medical school now in Mobile. And the price is right, about $24 million.

About $24 million. That is not much more than the cost mentioned by Senator Simpson yesterday for the design—just the design—of a new hospital in Minneapolis.

The veterans approached me with their idea. I confess that at first I was relatively cool to it because it looked too good to be true. Nonetheless, I asked the VA to take a look at the hospital to see whether, in physical terms it would be usable. As the members of this committee are aware, there are a lot of hospitals for sale these days, and most of them are available because they are no longer suitable to serve as modern hospitals. One must, therefore, take a jaundiced view of the availability of a hospital that someone wants to sell to the VA.

Nonetheless, the VA agreed to take a look at Providence, and did so with a professional team from the Office of Construction in the Department of Medicine and Surgery. Let me read to the committee a couple of statements from the conclusions of its report, over the signature of the Director, Facility Planning Service, Department of Medicine and Surgery:

> The VA team concluded that the Providence Hospital is well maintained and in generally good condition. The newest construction is in excellent condition. . . . It is the team's belief that, if a programmatic determination were made to establish a VA medical center in Mobile, the Providence Hospital could be adapted to serve in this role. A detailed analysis would be needed to determine the cost of modifying Providence and thus the true costs of acquisition.

That is the VA's own people speaking, Mr. Chairman, and the committee staff has a copy of the full report.

That struck me, and everyone else who has read the report, as a pretty good conclusion. What it meant, of course, was that there was nothing inherent to the hospital and its facilities that militated against its possible conversion to a VA facility. I am told that that is really a rare conclusion in business of looking at existing hospitals to see whether they could serve in the VA role.

The veterans were also working with some of our colleagues in the other body, notably then-Congressman Jack Edwards. As a result, Congressman Montgomery, the Chairman of the House Committee, asked one of his senior people to take a look at the situation. That look, by an experienced and knowledgeable individual, suggested that "the matter be further pursued with the Administrator of Veterans' Affairs," with some recommendations, and I quote in part: ". . . the Administrator be urged to give serious consideration to the acquisition of Providence Hospital, Mobile, AL."

The report went on to say that if the VA wants to put a hospital in that region and does not want to use Providence, it should be made to show in detail why Providence is not suitable or economical, and to show that staffing and quality of care would be as easily done and as good elsewhere as it would be in Mobile.

That position seems pretty strong to me, and certainly suggests that the matter should be looked at fully and carefully. The committee staff has a copy of that report, too.

Let me add that, at my request, the chief counsel of this committee has also looked at the hospital, and found it to be in superb condition. I believe that he agrees with me that it is a logical, a sensible, and an economical way to go.

A subcommittee of the House Veterans' Affairs Committee just held a hearing about the matter last week in Mobile. The veterans of the area, the State government, the medical schools, and just about everyone else that one can think of support the proposal.

I will not go into any detail with all the other arguments for this particular way of addressing the needs of the veterans in that part of the country. I will say, however, that the merits of the case seem so compelling to me that I would support a close look at the situation no matter where it might be found, whatever State, anywhere in the country.

Yet the VA cannot seem to get very interested in the problem. There are some reasons for that, although they do not seem to be compelling when one looks at the costs involved and the potential savings.

The service area for a hospital in Mobile might be somewhat different from one in Fort Walton Beach, FL, although Mobile is the center of a far larger concentration of underserved veterans. The disadvantages, if any, of the location might well be offset by the cost savings of Mobile and by the possibility that Mobile could be a tertiary care hospital affiliated with a very good medical school.

The VA is concerned that location of a hospital in Mobile might decrease the business in other hospitals in the area, including those in Montgomery, AL, and Biloxi, MS. That might be the case, although one should evaluate the cost savings of the Mobile option in comparison with the necessity to reevaluate the missions of the other hospitals affected. It is clear, however, that the veterans of the region are, on the whole, underserved, and the veterans themselves will tell you about the hardships imposed by the current lack of adequate and effective service. They have told me about it emphatically.

If we use an average cost per bed for a new hospital in 1984 dollars, which the VA has given as about $300,000 per bed in this location, a 225-bed hospital in Fort Walton Beach would cost something like $67.5 million. I doubt that there are very many of us who do not expect that the cost would increase substantially, in both dollar and real terms, by the time that the VA gets around to building that hospital, if it gets around to it at all.

By contrast, Providence could be bought as is, and fully equipped, for something like $25 million. With 349 beds, the cost per bed would be $71,500. Even if we assume that it might cost, say, $15 million to convert the facility to VA standards and usage patterns, the cost per bed is only $115,000, or about one-third of the estimated cost that we might expect for new construction. And there is a lot of other stuff that comes free for that price, such as a facility that would serve well as a nursing home.

In other words, Mr. Chairman, we could save a minimum of $25 or $30 million over the total cost of new construction, get more beds and a lot of other things in the bargain, and have an operating hospital several years sooner. After all, it takes something like 4 to 8 years from initial funding to activation of a hospital.

I do not deny that there are costs involved in saving money in this instance. There would have to be readjustments in hospital service areas, the location in the region may not be precisely ideal—although it is pretty good—and the VA would have to wrench itself out of its traditional pattern of providing hospitals only through new construction.

Nonetheless, the monetary savings would be substantial, and our veterans, in their own view, would benefit greatly. And that is what it is all about, Mr. Chairman.

There are a couple of other ways that the committee might proceed if the members believe that we should address the situation.

First, Mr. Chairman, I have suggested to you that the committee might provide, in the fiscal year 1986 construction resolution, for a sum of money to have an impartial study conducted to see whether the acquisition of Providence makes sense in both programmatic and financial terms. I am fully confident that such a study would confirm that Providence is the way to go if we want to find the most cost-effective way to provide excellent service to the veterans of the area.

Second, and I confess that this appeals to me more, we could ask the VA to take this particular case on as a pilot project for the acquisition, conversion and operation of existing facilities. In my view, we are going to have to go that way sooner or later, and it would be difficult to find a more congenial test case than Providence Hospital.

Since there is general agreement in principle that we are going to have to try to use existing facilities for veterans' health care, let's get on with it and get some first-hand experience with costs, problems, and opportunities.

Finally, Mr. Chairman, let me say that I am disappointed with the way the VA has reacted to and handled this matter, that is, below the national level. I would have thought that competent, thinking officials who are truly concerned about the provision of service to veterans would have jumped at the opportunity to do something innovative and cost effective. Instead, what I, and the veterans of Alabama, have encountered at every turn has been closed minds and arguments that might be summed up as "It's not in the plan, so we cannot do it."

In my view, and I have said this to the Administrator, the case for the acquisition of Providence Hospital is so compelling that the question to be addressed is not "should we do it" but "is there any reason why we should not do it?"

Thank you, Mr. Chairman. I am ready to answer any questions that you and our colleagues may have. If there is information that I do not have immediately at hand I will, of course, provide it for the record.

Chairman MURKOWSKI. Thank you very much, Senator Denton.

[The prepared statement of Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama, follows:]

PREPARED STATEMENT OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

MR. CHAIRMAN, I AM PLEASED TO HAVE THE OPPORTUNITY TO TESTIFY TO THE COMMITTEE ON AN ISSUE THAT IS OF GREAT CONCERN TO ME AS A MEMBER OF THE COMMITTEE AND, IN A PARTICULAR SENSE, IS OF GREAT CONCERN TO VETERANS IN MY STATE.

FOR EACH OF THE FOUR YEARS THAT I HAVE BEEN A MEMBER OF THE COMMITTEE, THE V.A. HAS REQUESTED LARGE SUMS OF MONEY TO BUILD NEW HOSPITALS TO SERVE OUR VETERANS. THE COSTS OF THE NEW HOSPITALS ARE SUBSTANTIAL, AND WE SEE WITH SOME FREQUENCY THE CONSTRUCTION OF LARGE, MODERN, EXPENSIVE FACILITIES IN LOCALITIES WHERE IT IS DIFFICULT TO JUSTIFY THE SIZE AND THE COST. THE EXAMPLE OF THE NEW HOSPITAL IN HOUSTON COMES IMMEDIATELY TO MIND, AND I KNOW THAT SEVERAL OF MY COLLEAGUES ON THE COMMITTEE ARE CONCERNED ABOUT IT.

I HAVE TAKEN A QUICK LOOK AT THE COSTS OF RECENTLY ACTIVATED V.A. HOSPITAL FACILITIES, AND I THINK THAT IT IS

KIND OF INTERESTING. FOR TEN HOSPITALS ACTIVATED BETWEEN 1973 AND 1984, RANGING IN SIZE FROM 205 BEDS TO 1,305 BEDS, THE COSTS PER BED OF THE TOTAL PROJECT, IN 1984 DOLLARS, RANGED FROM A LOW OF $95,000 TO A HIGH OF $313,000. THE AVERAGE COST PER BED FOR THE 5,951 BEDS BUILT WITH $1 BILLION, 117 MILLION 1984 DOLLARS WAS ABOUT $188,000.

I MUST SAY, MR. CHAIRMAN, THAT I HAVE NOT NOTICED ANY CONCRETE INCLINATION ON THE PART OF THE VETERANS ADMINISTRATION TO DEAL WITH THAT PROBLEM BY FINDING LESS EXPENSIVE OR MORE COST-EFFECTIVE WAYS TO PROVIDE NECESSARY NEW OR REPLACEMENT BEDS. INDEED, THE V.A. TAKES PRIDE IN THE FACT THAT IT HAS NOT IN ITS HISTORY ACQUIRED EXISTING HOSPITALS -- OTHER THAN ITS INITIAL TAKING OVER OF EXISTING MILITARY HOSPITALS -- AND THAT IT BUILDS NEW FACILITIES OF THE MOST MODERN AND, I MUST SAY, MOST EXPENSIVE KIND.

EVERYONE WHO HAS LOOKED AT THE PROBLEM SAYS THAT IF THE V.A. IS GOING TO CONTINUE TO ADD HOSPITALS (AND I BELIEVE IT MUST,) IT NEEDS TO FIND A LESS EXPENSIVE WAY TO DO IT. THE CONGRESSIONAL BUDGET OFFICE, THE OFFICE OF MANAGEMENT AND BUDGET, AND THE V.A. ITSELF HAVE ALL SAID THAT THE V.A. MAY WELL HAVE TO, OR SHOULD, CONSIDER THE LEASE OR PURCHASE OF EXISTING HOSPITAL FACILITIES. YET I HAVE YET TO SEE ANY ACTION FROM THE V.A. TO EXPLORE OR IMPLEMENT THAT CONCEPT.

THE PROBLEM HAS BEEN BROUGHT HOME TO ME BY A SITUATION IN MY STATE THAT SEEMS TO PROVIDE AN UNEXCELLED OPPORTUNITY.

AS BACKGROUND, IT IS IMPORTANT TO UNDERSTAND THAT THE V.A. PLANNING PROCESS FOR THE MEDICAL DISTRICT THAT INCLUDES ALABAMA, THE FLORIDA PANHANDLE, AND SOUTHEASTERN MISSISSIPPI HAS FOR SEVERAL YEARS PROVIDED FOR THE CONSTRUCTION OF A NEW V.A. HOSPITAL, IN THE EARLY 1990S, TO SERVE THE VETERANS LOCATED IN THE FLORIDA PANHANDLE, SOUTH ALABAMA, AND A SMALL PORTION OF GEORGIA. THE PROCESS THAT PRODUCED THAT PLAN WAS MANDATED BY CONGRESS, AND THE DOCUMENT THAT LAYS OUT THE PLAN IS CALLED "THE FLORIDA PANHANDLE WORKBOOK." WE ARE TALKING ABOUT AN EXPENSIVE NEW HOSPITAL TO BE LOCATED IN THE PANHANDLE, AND AT A PLACE -- FORT WALTON BEACH -- WHERE THERE IS NO MEDICAL SCHOOL WITH WHICH TO ESTABLISH AN AFFILIATION.

IT IS, THEREFORE, CLEAR THAT THE V.A. HAS ACCEPTED THE NEED FOR A NEW HOSPITAL IN THE REGION. THERE MAY, HOWEVER, BE SOME QUESTION ABOUT WHERE TO PUT IT.

LAST YEAR, AND BY COINCIDENCE, A VERY FINE PRIVATE HOSPITAL IN MOBILE, ALABAMA, -- PROVIDENCE HOSPITAL -- BECAME AVAILABLE BECAUSE ITS OWNERS AND OPERATORS -- THE SISTERS OF MERCY -- ARE BUILDING A NEW HOSPITAL IN A

DIFFERENT PART OF TOWN. THEY ARE NOT BUILDING A NEW HOSPITAL BECAUSE THERE IS ANYTHING WRONG WITH THE OLD ONE, LARGE PARTS OF WHICH ARE NEW AND ALL OF WHICH IS WELL MAINTAINED. THEY ARE BUILDING BECAUSE OF A PERCEPTION THAT THEIR SERVICE MISSION REQUIRED A DIFFERENT LOCATION. INDEED, I HAVE BEEN ADVISED INFORMALLY THAT, WERE THE DECISION BEING MADE TODAY INSTEAD OF SEVERAL YEARS AGO, THE SISTERS WOULD PROBABLY NOT DECIDE TO BUILD A NEW HOSPITAL.

IN ANY CASE, THE DIE IS CAST. THE VETERANS IN THE AREA SAW THE AVAILABILITY OF PROVIDENCE AS A BOON TO ADDRESS A SITUATION IN WHICH IT WAS CLEAR THAT THE V.A. ITSELF SAW THE NEED FOR A NEW HOSPITAL BUT IN WHICH THAT NEW HOSPITAL WOULD BE MANY YEARS IN THE MAKING AND COST A GREAT DEAL OF MONEY. THEY DEVELOPED THE VIEW THAT THE V.A., THE TAXPAYERS, AND THE VETERANS WOULD BE BETTER SERVED IF THE V.A. ACQUIRED PROVIDENCE AS A V.A. FACILITY RATHER THAN BUILDING A NEW HOSPITAL.

THERE WERE SOME ADDITIONAL CONSIDERATIONS THAT WERE INVOLVED IN THE DECISION. PROVIDENCE HOSPITAL IS RELATIVELY LARGE, WITH 349 ACUTE CARE BEDS, AND HAS AN ADJACENT 126 BED SCHOOL OF NURSING WHICH COULD BE USED FOR A VETERANS NURSING HOME. THERE ARE NO NURSING HOME BEDS CURRENTLY AVAILABLE IN SOUTH ALABAMA. THE GROUNDS ARE ABOUT 15.3 ACRES, WITH 1000 paved parking spaces. There is a residence with space to house 13 employees. The hospital has the most modern facilities and equipment, all of which are available for purchase. In addition, the hospital could easily be a very good tertiary care facility because of its existing capabilities and the possibility of affiliating with a good medical school in Mobile. And the price is right, about $24 million.

I repeat, about $24 million. That is not much more than the cost mentioned by Senator Simpson yesterday for the design -- just the design -- of a new hospital in Minneapolis.

The veterans approached me with their idea. I confess that I was relatively cool to it at first because it looked too good to be true. Nonetheless, I asked the V.A. to take a look at the hospital to see whether, in physical terms it would be usable. As the members of the Committee no doubt are aware, there are a lot of hospitals for sale these days, and most of them are available because they are no longer suitable to serve as modern hospitals. One must, therefore, take a jaundiced view of the availability of a hospital that someone wants to sell to the V.A.

Nonetheless, the V.A. agreed to take a look at Providence, and did so with a professional team from the Office of Construction in the Department of Medicine and Surgery. Let me read to the Committee a couple of statements from the conclusions of its report, over the signature of the Director, Facility Planning Service, Department of Medicine and Surgery:

> The V.A. team concluded that the Providence Hospital is well maintained and in generally good condition. The newest construction is in excellent condition. . . . It is the team's belief that if a programmatic determination were made to establish a VA medical center in Mobile, the Providence Hospital could be adapted to serve in this role. A detailed analysis would be needed to determine the cost of modifying Providence and thus the true costs of acquisition.

That's the V.A.'s own people speaking, Mr. Chairman, and the Committee staff has a copy of the full report.

That struck me, and everyone else who has read the report, as a pretty good conclusion. What it meant, of course, was that there was nothing inherent to the hospital and its facilities that militated against its possible

CONVERSION TO A V.A. FACILITY. I AM TOLD THAT THAT IS REALLY A RARE CONCLUSION IN BUSINESS OF LOOKING AT EXISTING HOSPITALS TO SEE WHETHER THEY COULD SERVE IN THE V.A. ROLE.

THE VETERANS WERE ALSO WORKING WITH SOME OF OUR COLLEAGUES IN THE OTHER BODY, NOTABLY THEN-CONGRESSMAN JACK EDWARDS. AS A RESULT, CONGRESSMAN MONTGOMERY, THE CHAIRMAN OF THE HOUSE COMMITTEE, ASKED ONE OF HIS SENIOR PEOPLE TO TAKE A LOOK AT THE SITUATION. THAT LOOK, BY AN EXPERIENCED AND KNOWLEDGEABLE INDIVIDUAL, SUGGESTED THAT "THE MATTER BE FURTHER PURSUED WITH THE ADMINISTRATOR OF VETERANS' AFFAIRS," WITH SOME RECOMMENDATIONS, AND I QUOTE IN PART:

> . . . THE ADMINISTRATOR BE URGED TO GIVE SERIOUS CONSIDERATION TO THE ACQUISITION OF PROVIDENCE HOSPITAL, MOBILE, ALABAMA.

THE REPORT WENT ON TO SAY THAT IF THE V.A. WANTS TO PUT A HOSPITAL IN THAT REGION AND DOES NOT WANT TO USE PROVIDENCE, IT SHOULD BE MADE TO SHOW IN DETAIL WHY PROVIDENCE IS NOT SUITABLE OR ECONOMICAL, AND TO SHOW THAT STAFFING AND QUALITY OF CARE WOULD BE AS EASILY DONE AND AS GOOD ELSEWHERE AS IT WOULD BE IN MOBILE.

THAT POSITION SEEMS PRETTY STRONG TO ME, AND CERTAINLY SUGGESTS THAT THE MATTER SHOULD BE LOOKED AT FULLY AND CAREFULLY. THE COMMITTEE STAFF HAS A COPY OF THAT REPORT TOO.

LET ME ADD THAT, AT MY REQUEST, THE CHIEF COUNSEL OF THIS COMMITTEE HAS ALSO LOOKED AT THE HOSPITAL, AND FOUND IT TO BE IN SUPERB CONDITION. I BELIEVE THAT HE AGREES WITH ME THAT IT IS A LOGICAL, A SENSIBLE, AND AN ECONOMICAL WAY TO GO. A SUBCOMMITTEE OF THE HOUSE VETERANS AFFAIRS COMMITTEE JUST HELD A HEARING ABOUT THE MATTER LAST WEEK IN MOBILE. THE VETERANS OF THE AREA, THE STATE GOVERNMENT, THE MEDICAL SCHOOLS, AND JUST ABOUT EVERYONE ELSE THAT ONE CAN THINK OF SUPPORT THE PROPOSAL.

I WON'T GO INTO DETAIL WITH ALL THE OTHER ARGUMENTS FOR THIS PARTICULAR WAY OF ADDRESSING THE NEEDS OF THE VETERANS IN THAT PART OF THE COUNTRY. I WILL SAY, HOWEVER, THAT THE MERITS OF THE CASE SEEM SO COMPELLING TO ME THAT I WOULD SUPPORT A CLOSE LOOK AT THE SITUATION NO MATTER WHERE IT MIGHT BE FOUND, ANYWHERE IN THE COUNTRY.

YET THE V.A. CANNOT SEEM TO GET VERY INTERESTED IN THE PROBLEM. THERE ARE SOME REASONS FOR THAT, ALTHOUGH THEY DO NOT SEEM TO ME TO BE COMPELLING WHEN ONE LOOKS AT THE

COSTS INVOLVED AND THE POTENTIAL SAVINGS. THE SERVICE AREA FOR A HOSPITAL IN MOBILE MIGHT BE SOMEWHAT DIFFERENT FROM ONE IN FORT WALTON BEACH, FLORIDA, ALTHOUGH MOBILE IS THE CENTER OF A FAR LARGER CONCENTRATION OF UNDER-SERVED VETERANS. THE DISADVANTAGES, IF ANY, OF THE LOCATION MIGHT WELL BE OFFSET BY THE COST SAVINGS OF MOBILE AND BY THE POSSIBILITY THAT MOBILE COULD BE A TERTIARY CARE HOSPITAL AFFILIATED WITH A VERY GOOD MEDICAL SCHOOL.

THE V.A. IS CONCERNED THAT LOCATION OF A HOSPITAL IN MOBILE MIGHT DECREASE THE BUSINESS IN OTHER HOSPITALS IN THE AREA, INCLUDING THOSE IN MONTGOMERY, ALABAMA, AND BILOXI, MISSISSIPPI. THAT MIGHT BE THE CASE, ALTHOUGH ONE SHOULD EVALUATE THE COST SAVINGS OF THE MOBILE OPTION IN COMPARISON WITH THE NECESSITY TO REEVALUATE THE MISSIONS OF THE OTHER HOSPITALS' AFFECTS. IT IS CLEAR, HOWEVER, THAT THE VETERANS OF THE REGION ARE, ON THE WHOLE, UNDER-SERVED, AND THE VETERANS THEMSELVES WILL TELL YOU ABOUT THE HARDSHIPS IMPOSED BY THE CURRENT LACK OF ADEQUATE AND EFFECTIVE SERVICE.

IF WE USE AN AVERAGE COST PER BED FOR A NEW HOSPITAL IN 1984 DOLLARS, WHICH THE V.A. HAS GIVEN AS ABOUT $300,000 PER BED IN THIS LOCATION, A 225 BED HOSPITAL IN FORT WALTON BEACH WOULD COST SOMETHING LIKE $67.5 MILLION. I DOUBT THAT

THERE ARE VERY MANY OF US WHO DO NOT EXPECT THAT THE COST WOULD INCREASE SUBSTANTIALLY, IN BOTH DOLLAR AND REAL TERMS, BY THE TIME THAT THE V.A. GETS AROUND TO BUILDING THAT HOSPITAL, IF IT GETS AROUND TO IT AT ALL.

BY CONTRAST, PROVIDENCE COULD BE BOUGHT AS IS, AND FULLY EQUIPPED, FOR SOMETHING LIKE $25 MILLION. WITH 349 BEDS, THE COST PER BED WOULD BE $71,500. EVEN IF WE ASSUME THAT IT MIGHT COST, SAY, $15 MILLION TO CONVERT THE FACILITY TO V.A. STANDARDS AND USAGE PATTERNS, THE COST PER BED IS ONLY $115,000, OR ABOUT ONE-THIRD OF THE ESTIMATED COST THAT WE MIGHT EXPECT FOR NEW CONSTRUCTION. AND THERE IS A LOT OF OTHER STUFF THAT COMES FREE FOR THAT PRICE, SUCH AS A FACILITY THAT WOULD SERVE WELL AS A NURSING HOME.

IN OTHER WORDS, WE COULD SAVE A MINIMUM OF 25 OR 30 MILLION DOLLARS OVER THE TOTAL COST OF NEW CONSTRUCTION, GET MORE BEDS AND A LOT OF OTHER THINGS IN THE BARGAIN, AND HAVE AN OPERATING HOSPITAL SEVERAL YEARS SOONER. AFTER ALL, IT TAKES SOMETHING LIKE FOUR TO EIGHT YEARS FROM INITIAL FUNDING TO ACTIVATION OF A HOSPITAL.

I DO NOT DENY THAT THERE ARE COSTS INVOLVED IN SAVING MONEY IN THIS INSTANCE. THERE WOULD HAVE TO BE READJUSTMENTS IN HOSPITAL SERVICE AREAS, THE LOCATION IN THE region may not be ideal -- although it is pretty good --, and the V.A. would have to wrench itself out of its traditional pattern of providing hospitals only through new construction.

Nonetheless, the monetary savings would be substantial, and our veterans would benefit greatly. And that's what it is all about.

Mr. Chairman, there are a couple of ways that the Committee might proceed if the members believe that we should address the situation.

First, Mr. Chairman, I have suggested to you that the Committee might provide, in the FY'86 Construction Resolution, for a sum of money to have an impartial study conducted to see whether the aquisition of Providence makes sense in both programmatic and financial terms. I am fully confident that such a study would confirm that Providence is the way to go if we want to find the most cost-effective way to provide service to the veterans of the area.

Second, and I confess that this appeals to me more, we could ask the V.A. to take this particular case on as a pilot project for the acquisition, conversion, and operation of existing facilities. In my view, we are going to have to go that way sooner or later, and it would be difficult to find a more congenial test case than Providence Hospital. Since there is general agreement in principle that we are going to have to try using existing facilities for veterans health care, let's get on with it and get some first-hand experience with costs, problems, and opportunities.

Finally, Mr. Chairman, let me say that I am disappointed with the way that the V.A. has reacted to and handled this matter. I would have thought that competent, thinking officials who are truly concerned about the provision of service to veterans would have jumped at the opportunity to do something innovative and cost-effective. Instead, what I, and the veterans of Alabama, have encountered at every turn has been closed minds and arguments that might be summed up as "It's not in the plan, so we cannot do it."

In my view, and I have said this to the Administrator, the case for the acquisition of Providence Hospital is so compelling that the question to be addressed is not "should we do it" but "is there any reason why we should not do it."

Thank you, Mr. Chairman. I am ready to answer any questions that you and our colleagues may have. If there is information that I do not have immediately at hand, I will of course provide it for the Record.

Chairman Murkowski. I know that you have other commitments this morning, but I am curious as to a comment made on page 4 of your testimony. You stated that "because of a perception that their service mission required a different location the sisters would be moving from one area of the community to another." Could you elaborate a bit more as to why they would want to move across town to build a new hospital?

Senator Denton. Yes. I will give you my own concept of that. You would have to ask the sisters if you wanted to get an absolutely authentic and authoritative answer.

The neighborhood is a good neighborhood. The whole, about half the whole large square block involves the nursing facility and the hospital and the parking lot that I referred to. Across the street is a city park, a beautiful city park. It is on one of the nicest streets in Mobile, AL. It is an ideal location. However, as operated by the Sisters of Mercy, they have some need to maintain a reasonably sound financial basis there. In other words, there must be some kind of a reasonable return for the services rendered.

They are known as the Sisters of Mercy. They do provide services which often are entirely charitable. And the balance, I believe, between that which was entirely charitable and that which had some kind of reasonable recompense was becoming unfavorable. And I believe that had something to do with the desire for relocation. That consideration would have nothing to do with the location of a veterans hospital.

Chairman Murkowski. Well, I would assume that a new hospital would cost the Sisters a substantial sum. Since they are going to continue to serve the community, I am wondering if economics are a factor here. Perhaps a new hospital would be more efficient and, be better able to provide a return.

Tony Principi has been down there and looked at it and concurs that it is a fine facility. Just from the standpoint of the debt service attached to a new hospital, I am wondering why it is not sufficient for the community, yet would be sufficient for a VA hospital?

Senator Denton. In my view it was more than sufficient to the needs of the community. As I said, I think it had something to do with the balance between the clientele which can pay some portion and that portion of the clientele which can pay none, and an unfavorable balance in that respect.

The clientele which would be of the proper mix of ability and inability to pay is about 5 miles or 3 miles west of that hospital. And that is where they decided to make the move. It had nothing to do with the efficiency or modernity of the hospital.

But again, I suggest you ask the Sisters of Mercy about that. I believe that is the general idea.

Chairman Murkowski. What we would like to have for the record is an explanation as to why they are moving and why it would be advantageous for them as it relates to the provision of services.

Senator Denton. I would be pleased to submit that for the record, Mr. Chairman.

[The information referred to above is available in the committee's files.]

Chairman **Murkowski**. The other point, Senator Denton, is the question of the use of existing facilities. You have challenged the VA as to why they do not utilize existing facilities.

Thus, what we are doing here is plowing new ground, with the suggestion that it is in the best interest of the VA to consider utilizing existing facilities.

You are also aware, Senator, that——

Senator **Denton**. Excuse me, Mr. Chairman. Before you leave that point if you would yield.

Chairman **Murkowski**. I would yield.

Senator **Denton**. It is not my idea that we consider a less expensive way to go than continuing to habitually add new hospitals, it is the idea of the Congressional Budget Office, the Office of Management and Budget and the VA itself, which in its own pamphlets have said that the VA may well have to or should consider the lease or purchase of existing hospital facilities.

So I do commend and concur with that trend, because we are going to have the increasing need and we have got to just be a little less profligate with the means which we are scattering about for new hospitals when an older facility, an existing facility rather, would serve just as well. I think that is the only way we are going to find ourselves able to meet the increasing medical needs of our veterans within the constraints of budget, without prejudice to the quality of care.

Chairman **Murkowski**. You mentioned also a cost comparison of VA hospitals during your opening remarks concerning a range of $95,000 to $313,000 per bed. I believe you referred to the Houston Hospital in that range. Is that correct or incorrect?

Senator **Denton**. I do not——

Chairman **Murkowski**. I do not see it in your testimony.

Senator **Denton**. I did not give or estimate a cost for the Houston Hospital. Those figures I gave were for 10 hospitals activated between 1973 and 1984. And those hospitals happen to range in size from 205 beds to 1,305 beds. And I gave the cost per bed of the total project ranging from the low—and these are specific cases—from a low of $95,000 per bed to a high of $313,000 per bed. And I gave the average cost for the 5,951 beds built, the total built, to be $188,000, Mr. Chairman.

Chairman **Murkowski**. Senator, we will receive testimony later today from representatives from the private sector. We will also receive testimony from the VA with regard to their estimated hospital cost per bed. Thank you for your testimony. I think it was challenging in the sense that the recommendations are certainly sound and have merit for consideration.

And you should be aware officially that there are 10 proposed recommendations in the VA's 1985 to 1989 construction plan. To my knowledge, this particular one has not been submitted by the VA, as far as their outyear planning process is concerned.

Senator **Denton**. On that point if you can yield, Mr. Chairman.

Chairman **Murkowski**. Please.

Senator **Denton**. I am aware, and as I indicated, they have designated this hospital to be built, which they have preconcluded they will do, build a new hospital.

Chairman **Murkowski**. Is that the Gainesville, FL, facility?

Senator **Denton**. Florida, the Panhandle. The Panhandle project which is in Fort Walton.

Chairman **Murkowski**. I would like to identify it by name.

Senator **Denton**. Fort Walton Beach is the one on there.

Chairman **Murkowski**. Well, we have Gainesville and we have Palm Beach County.

Senator **Denton**. OK. Well, in the future they are planning to build one at Fort Walton Beach.

Chairman **Murkowski**. This is another one then that we are not aware of.

Senator **Denton**. Yes. That's right. That is in their further on down the road planning. And we are suggesting that, rather than build a brand new one at that particular location, they purchase for a much more cost-effective result and an equally, at least an equally good, in fact, we believe a better service result because the University of South Alabama has an excellent medical school very close to our hospital. No such situation exists over there at Fort Walton Beach. And we suggest that the Veterans' Administration adopt the recommendation by all of those agencies I mentioned and consider, and when they consider they will conclude to buy an existing facility and adapt it and save a lot of money.

Chairman **Murkowski**. You have obviously submitted this proposal to the VA, and they have been down and looked at the facility. Have they given you a definitive answer as to whether they are going to consider it, reject it, or consider it later? What is the finality of their position?

Senator **Denton**. They have not given a definitive answer. They have not given a definitive answer, but the studies at the lower levels of the Veterans' Administration appear to reflect the bias, the propensity to buy new facilities, which I find absolutely counterproductive in terms of the thrust this Government must take if we are to provide for our needy, our deserving, in the most cost-effective way.

Chairman **Murkowski**. Senator, the committee would like to have submitted for the record any correspondence relative to the VA's position pertaining to this matter.

Senator **Denton**. We will so conform to that request, Mr. Chairman.

Chairman **Murkowski**. Thank you very much, Senator, for your testimony.

Senator **Denton**. Thank you, Mr. Chairman.

Chairman **Murkowski**. We wish you a good day.

We are also joined by Senator Gramm from the State of Texas. I will call on Senator Bentsen at this time. And he will be joined by Senator Gramm.

I am sure that these gentlemen have some recommendations for the committee.

Please proceed at your convenience.

TESTIMONY OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM THE STATE OF TEXAS

Senator **Bentsen**. Thank you very much, Mr. Chairman. I am delighted to be here with my colleague Senator Gramm. I am here to testify for the hospital in Houston, TX, which has been the No. 1 priority for the VA since 1983.

I understand the committee's desire to adhere to a maximum size of 700 beds for VA hospitals. I would like to say to the Chairman that I also think in hiring Booz-Allen that you have hired a very fine management consulting firm. I had that firm work for me when I was in the private sector, and they did a good job. But they were not always right. And they have some fallibility, as any management consulting firm would have.

What you have in Houston is a hospital of 1,047 beds, one that has been downsized partially twice in the past. If you think that you will have some savings in reducing the size to 700 beds you have to remember that, first, that is a question yet to be proven and, second, if you delay that hospital's construction by 2 to 3 years the resulting inflation will increase the cost of that hospital. Therefore, you have lost whatever savings you might have been seeking. The other problem that you run into is you have delayed the delivery of services to all of those veterans of that area for that period of time.

I understand that the Houston hospital was referred to as a Taj Mahal. Mr. Chairman, that is a bum rap. You are not really comparing apples to apples. Here you are talking about providing 200,000 to 300,000 outpatient visits a year. You cannot compare this kind of a hospital to a private hospital. In addition to that, you are talking about a VA hospital providing medical education facilities tied to Baylor College of Medicine. And I heard the previous witness talking about a case where they did not have that kind of compatibility or that kind of a school available. Here you have it.

In addition to that, you have dental care that is going to be available to the patients.

Now, when you add those additional things to this hospital you do not add a single additional bed, but you obviously add to the costs. So when you start dividing the number of beds into those total costs you are going to run into a large number. But even when you do that you find out that this particular hospital is certainly not out of line.

You heard Senator Denton referring to various costs around the country. Let me give you some specific ones. The cost per bed of the Houston hospital is $218,000 based on estimated 1986 construction costs. Now, that compares with $289,000 per bed cost of a VA hospital built in Loma Linda, CA, in 1977—that would be about 9 years prior to the time that this one is going to be completed, with all the ensuing inflation that took place in between—the $186,000 cost per bed of a hospital built in Augusta, GA, in 1980, and the $313,000 cost of a VA hospital built in the Bronx in 1981.

Since 1983, this modernization project has been a top priority of the VA health planners. And the veterans of the Houston area can ill afford further delay in the construction of these facilities to replace a deteriorating and decaying plant.

I have been in that hospital. It desperately needs modernization. Having worked for many years to try to get this hospital built I was certainly pleased with the administration's budget request of $190 million for phases one, two and four of the construction. I do hope that we are finally seeing a light at the end of the tunnel and that we are not going to face again delays to try to find some size that might be considered an optimum size.

I would like to remind the committee that the size that has been chosen is not some random selection, but was determined by the General Accounting Office and the VA in trying to develop a size that they thought would adequately serve the veterans of that area.

Mr. Chairman, I hope that we will not see further delay but that we will proceed in the construction of a facility that is desperately needed in that area.

And I would be delighted to yield to my colleague from Texas.

Chairman **Murkowski**. Thank you, Senator Bentsen.

[The prepared statement of Hon. Lloyd Bentsen, a U.S. Senator from the State of Texas, follows:]

PREPARED STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM THE STATE OF TEXAS

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE: THE VETERAN'S ADMINISTRATION HAS SET A PRIORITY FOR THE CONSTRUCTION OF HOSPITALS, AND I AM HERE TODAY TO SPEAK IN SUPPORT OF IT, AND TO URGE THE COMMITTEE TO HONOR THE PRIORITIES SET BY THE VA.

I UNDERSTAND THE COMMITTEE'S DESIRE TO ADHERE TO A POLICY OF PROVIDING CONSTRUCTION AUTHORIZATION FOR HOSPITALS NO LARGER THAN 700 BEDS. AS A COST-SAVINGS TOOL, I WOULD BE WILLING TO CONSIDER SUCH A PROPOSAL. BUT I WANT TO URGE THE COMMITTEE NOT TO BLINDLY FOLLOW SUCH A RULE, ONE THAT HAS NOT RECEIVED THE ENDORSEMENT OF THE FULL CONGRESS, WITHOUT GIVING PROPER CONSIDERATION TO THE DELAYS SUCH A PROVISION MIGHT CAUSE TO THE CONSTRUCTION OF HOSPITALS THAT HAVE ALREADY SUFFERED THROUGH ENOUGH RED TAPE AND ARE PROCEEDING AT A PACE NO FASTER THAN A SNAIL'S.

THE VETERAN'S ADMINISTRATION HAS GIVEN TOP PRIORITY TO THE CONSTRUCTION OF A 1,047 BED HOSPITAL IN HOUSTON TO REPLACE A

FACILITY THAT WAS ORIGINALLY DESIGNED BY THE NAVY IN 1946 AS A TEMPORARY REHABILITATION UNIT. SINCE 1979, THE PROJECT HAS BEEN IN THE PLANNING STAGE, AND IN FACT, THE ORIGINAL PLANS HAVE BEEN DOWNSIZED TWICE, FROM A 1,196 BED FACILITY IN 1980 TO 1,049 BEDS IN 1982, TO 1,047 BEDS IN 1984. I MIGHT REMIND THE COMMITTEE THAT THE NUMBER OF BEDS WAS NOT CHOSEN BY CHOOSING ANY ARBITRARY METHOD, BUT RATHER BY THE VA-GAO BED SIZING MODEL DESIGNED TO PREDICT NEED IN A GIVEN AREA.

SINCE 1983, THIS MODERNIZATION PROJECT HAS BEEN THE TOP PRIORITY OF VA HEALTH PLANNERS. THE VETERANS OF THE HOUSTON AREA CAN ILL-AFFORD FURTHER DELAY IN THE CONSTRUCTION OF THESE FACILITIES TO REPLACE A DETERIORATING AND DECAYING PLANT.

HAVING WORKED HARD TO ASSURE THOSE YEARS OF PLANNING WERE FUNDED, I WAS PLEASED WITH THE ADMINISTRATION'S BUDGET

REQUEST OF $190 MILLION FOR PHASES I, II, AND IV OF CONSTRUCTION. I WAS HOPEFUL THAT WE WERE SEEING THE END OF THE TUNNEL, AND THAT THE VETERANS OF THE HOUSTON AREA WOULD FINALLY BE ABLE TO RECEIVE THE MEDICAL CARE THEY DEMAND AND DESERVE IN A MODERN, ADEQUATE FACILITY.

IF THE COMMITTEE INSISTS ON APPLYING A 700 BED CAP ON THE HOUSTON VA HOSPITAL MODERNIZATION, THE HUNDREDS OF THOUSANDS OF VETERANS IN THE HOUSTON AREA WILL HAVE TO WAIT AN ADDITIONAL TWO OR THREE YEARS BEFORE CONSTRUCTION CAN BEGIN. IT IS NO SMALL FEAT TO REDESIGN A HOSPITAL FACILITY FROM 1,047 BEDS TO 700. THE PROJECT WOULD HAVE TO BE COMPLETELY REDESIGNED, FROM THE WORKING DRAWINGS UP.

THESE VETERANS HAVE ALREADY WAITED SIX YEARS. TO ALLOW THIS PROCESS TO DRAG ON INDEFINITELY FOR ANOTHER THREE YEARS BEFORE CONSTRUCTION FUNDS CAN EVEN BE DISCUSSED IS SIMPLY UNTENABLE.

ANY FURTHER DELAY IN CONSTRUCTION AT THE HOUSTON VA HOSPITAL IS NOT ONLY HARD FOR THESE VETERANS TO ACCEPT, IT ALSO RAISES A JUSTIFIABLE CONCERN FOR THE QUALITY OF CARE PROVIDED THOSE VETERANS WHO ARE SERVED BY THE HOUSTON HOSPITAL.

FOR THE SAKE OF THOSE VETERANS, FOR THE SAKE OF MEDICAL PROFESSIONALS ATTEMPTING TO DELIVER THE HIGHEST POSSIBLE QUALITY OF CARE, AND FOR THE SAKE OF THE KEEPING THE PROMISES MADE BY THIS GOVERNMENT TO THE VETERANS OF THE HOUSTON AREA, I URGE THE COMMITTEE TO APPROVE THE CONSTRUCTION OF THE HOUSTON FACILITY AT THE EARLIEST POSSIBLE DATE, WITH THE PRESENT DESIGN SO THAT WE CAN BEGIN TO WORK TOWARDS DELIVERING THE QUALITY OF CARE THESE VETERANS OUGHT TO BE RECEIVING. MR. CHAIRMAN, THE SITUATION IN HOUSTON IS EXTREMELY SERIOUS, AND IT WARRANTS IMMEDIATE ACTION.

I APPRECIATE THE COMMITTEE AFFORDING ME THIS OPPORTUNITY TO MAKE THE CASE FOR INITIATING CONSTRUCTION OF THE HOUSTON VA HOSPITAL AS IT IS PRESENTLY DESIGNED. I HOPE THE COMMITTEE WILL SEE THE WISDOM OF MOVING QUICKLY TO CORRECT THE SITUATION IN HOUSTON.

Chairman MURKOWSKI. Senator Gramm.

TESTIMONY OF HON. PHIL GRAMM, A U.S. SENATOR FROM THE STATE OF TEXAS

Senator GRAMM. Mr. Chairman, I want to thank you for having us here to testify today.

I would like to begin by talking about the hospital. I would like to talk about the evolution which has occurred in its cost. I would like to talk about the need, and then join my senior Senator, Senator Bentsen, in answering your questions.

First of all, I think it is important to remind the committee that this hospital was not built by the VA. This hospital was built by the Navy and completed in 1946. It was built by wartime standards and was designed to last between 5 and 10 years.

The VA took over the hospital facility and it has been expanded. Much of the construction is wood. And by any standard, measured by any agency, it is a fire hazard and a construction hazard.

I have been in a lot of veterans' hospitals. My dad died in a veterans' hospital. As a member of the Veterans' Committee in the House for 6 years, I have been in veterans' hospitals all over this country. And I can tell this committee that this is the worst facility that I have ever seen in the VA hospital system. I have no doubt about the fact that this facility, in terms of the physical plant, is probably the worst hospital facility currently operating in the country.

I think it is a great testament to the staff there that the quality of care is uniformly high.

And I would like to reinforce the point that Senator Bentsen made: This is not just some VA hospital in Texas, this is a hospital located in the general area of the Texas Medical Center, it has staff sharing with one of the finest medical centers in the world. This facility is the flagship of the VA hospital system in Texas. It is a facility that, regardless of what we decide about the case load, we can always fill and provide a level of quality and critical care that cannot be provided anywhere else in the Southwest.

Under Public Law 96-22, we required that the Veterans' Administration set out its priorities in terms of construction. And in 1979, the VA system set out 10 priority hospitals for construction. The Houston hospital was on that list in 1979, and it has been on that list ever since. It is the number one priority in the VA system today.

Now, I would like to note, Mr. Chairman, that unlike most construction projects that I have observed in my 7 years here in Washington, the projected costs on this project have gone down, not up. I remind the committee that in 1980 the projected costs of this project were between $335 million and $400 million. In 1982 those costs were revised down to a range of between $300 million and $310 million. The cost today is $252 million. We have seen, in other words, a reduction of over $100 million in the projected cost of this facility.

I would also like to remind the committee of two additional points, Mr. Chairman. The first point is that this facility has already been downsized. In its initial authorization it had a total bed size of 1,060. In 1980 the bed size in terms of hospitals was 1,196. That was downsized in 1982 to 1,049 and has been downsized in the final projection in 1984 to 927 hospital beds.

In terms of the nursing home, as we have looked at the demographics of the region, the nursing home facility there was initially at 78 beds. It has been raised to 120 and has stayed at that level ever since.

Finally, let me remind the committee that we have released on March 14 the architectural and engineering funds for final construction documents. This project is ready to build. It is desperately needed. The current facility is a disgrace to the veterans' medical system. It is a fire hazard. It is a construction hazard. We need this facility. It is in the midst of one of the finest medical centers in the world. If we have problems in terms of lack of occupancy, given standards we may set in the future, this can be a referral hospital for our whole region of the country.

I urge the committee to move ahead with funding. We have waited on this critically needed facility for a long time. We have waited for our turn, in terms of priority to arrive. We are now at the top of the list. In a very tight budget that the President has submitted I think it is important to note that he submitted funding to construct this facility. We think it is needed, and obviously we are here to make that argument.

Chairman **Murkowski**. Gentlemen, you have made an excellent case. You have noted that inefficiencies exist with regard to the age and design of the existing hospital.

There has been and continues to be some discussion as to the size of the proposed Houston hospital. The question is whether 1,047 beds is indeed bigger than is customary. However, I guess the question what is customary is incidental, because hospitals range in all sizes.

One concern that has been brought out from time to time is the occupancy rate of the existing Houston VAMC, which is estimated to be about 84 percent. Now, that may not mean much until you consider the number of service-connected veterans that are currently utilizing that facility. It is about 8.4 percent. The VA's obligation is not to provide care to all veterans, but to provide care to non-service-connected on a space available basis. It appears that the percentage of service-connected veterans receiving care at Houston is quite low at 8.4 percent.

When we talk about costs I assume that you are referring to completed project costs when you give me your figure of about $218,000 per bed. Is that not correct?

Senator **Bentsen**. That is my understanding of the costs.

Senator **Gramm**. Mine as well.

Mr. Chairman, if I could, let me inject just——

Chairman **Murkowski**. Well, let me finish this particular point.

Senator **Gramm**. Fine.

Senator **Bentsen**. What I would like to say on that, Mr. Chairman, is I understand that the figures that were provided to me are comparing the same completion level with the hospital in Loma Linda and in Augusta, GA, and the VA hospital built in the Bronx that I had cited.

Chairman **Murkowski**. Senator, I would assume that those figures that you gave me indicate the Houston cost per bed is much less, at $218,000, compared to $289,000, for the Loma Linda facility, and $313,000 for the Bronx facility. The point I want to make is that the VA has provided us with the total project costs on the hospital in Houston at $252 million. Now, it does not take a mathematical genius to divide 1,047 beds and come up with a figure of about $252,000 per bed cost. Now, that is total per bed cost for the Houston project.

It is interesting further to note that when we asked the VA for the cost they come up with $165,000 per bed. However, their cost is construction alone. Not included are the additional costs associated with the project. Costs such as tearing down the other building and putting in the necessary facilities to make the project a completed one.

It does not do us any good to have figures that are not comparative. When we consider Loma Linda and the Bronx, those are finished project costs. I can only assume that we have a discrepancy here between the figures that you have given me and what is requested in the VA's budget for medical facility construction programs, volume 3, for fiscal year 1986, which lists the total estimated project cost at $252 million.

Senator **Bentsen**. I understand, Mr. Chairman. I had been advised that these were comparable costs that had been provided to me. But I would be happy to check those.

Chairman **Murkowski**. Well, I think we are both going to go back and check some of these figures.

Senator **Bentsen**. Of course.

Chairman **Murkowski**. I believe it is appropriate that we do so. It is interesting to note that we have no assurance that the bids are going to come in. I think the Loma Linda VAMC was an extraordinary example of costs which completely ran away from reality. I intend, during this hearing process, to question the VA on the process of how they put out their construction bids. I assume that they do not let the contracts until the architectural designs have been completed. That way it reduces the number of change orders. So when the contractor bids, it is a firm bid, the bond is put up, and as a consequence we have a relatively turnkey cost. We do not begin to design further after we start construction.

Senator **Bentsen**. Mr. Chairman, I have been down that road, and I could not agree with you more in that regard. But let me also say that the timing for building in Houston could not be better. You have got a situation where the Houston construction industry is in a recession. You have all kinds of contractors and a labor force looking for work. I think you would have very competitive bids. In fact, I would judge that you would get the most competitive bids that you would get anyplace in the State at this time.

Senator **Gramm**. Let me add, Mr. Chairman, if I may, that I believe the major reason that we have seen a decline in the projected costs is because of the building situation in Houston. And I think it is quite possible that we might get a competitive bid that could be below the 252.

I would like, if I could, very briefly to go back and address two other points. In terms of occupancy, you have to realize that this is a naval convalescent hospital, not a modern hospital, so it has these huge long wards, with bed, after bed, after bed. There has been a lot of expansion and contraction over time, so that I would argue that an 80-percent occupancy in this hospital is still roughly the equivalent of having a lot of people out in hallways in other hospitals.

The final point I would like to make—and I do not want to be overly dramatic—but I do believe that we sometimes can get a false impression in trying to make a total distinction between service-connected and non-service-connected patients. Someone who served in the First Division and who fought in Africa, Sicily, Normandy, and all through Europe to the end of the war and happened not to be injured or wounded is a non-service-connected veteran. A person who signed up and joined the Navy and who showed up for their formation and a lawnmower came by and threw a rock in their eye is service-connected.

So the distinction is not always as clear cut as the general public might perceive it to be. It is a question of whether they were wounded or injured while they were in service—combat or noncombat.

Chairman Murkowski. Do you have a rough idea of the number of beds which are empty in the other hospitals in the Houston area?

Senator Bentsen. No; I do not have that figure. But I would be happy to provide for the record such information as we are able to find in that regard.

Chairman Murkowski. The committee has been advised that there are 167,773 private sector hospital beds empty in Houston each month.

Senator Bentsen. Well—I would--I would estimate what you are running into there is a situation where you have a great medical center, and when you cite numbers like that as compared to other parts of the country, those numbers would not be out of line. You have a vast number of beds available.

Chairman Murkowski. It indicates that there is a nonutilization of hospital beds. The question is, is it appropriate that consideration be given to veterans to use those beds? That is an entirely different argument.

Senator Bentsen. That is another ballgame, Mr. Chairman.

Chairman Murkowski. It certainly is.

Senator Bentsen. And if you are going to do that then you put in question any hospital built for the veterans.

Chairman Murkowski. I would look forward to any clarifications you would care to make for the record with regard to the estimated costs per bed. We have a difference in our figures of about $30,000 per bed.

Senator Bentsen. I would be very pleased to.

[Subsequently, Hon. Lloyd Bentsen, a U.S. Senator from the State of Texas, submitted the following information in the form of a letter, dated March 29, 1985:]

LLOYD BENTSEN
TEXAS

COMMITTEES
FINANCE
ENVIRONMENT AND PUBLIC WORKS
JOINT ECONOMIC
SELECT COMMITTEE
ON INTELLIGENCE
JOINT COMMITTEE
ON TAXATION

United States Senate
WASHINGTON D.C. 20510

March 29, 1985

The Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Frank:

I am writing you in reference to a question you asked me at a Veterans' Affairs Committee hearing on Wednesday, March 27th.

Your question concerned figures that I had used to compare the bed costs of the proposed Houston VA replacement hospital and Veterans' Administration hospitals in Loma Linda, California, Augusta, Georgia and Bronx, New York. You indicated that the bed-cost figures in our records for those facilities were different from those cited by me. I informed you that I would submit clarification of the numbers that I used and that is the purpose of this letter.

In my testimony before the Committee I cited bed cost figures, for Houston, Loma Linda, Augusta and the Bronx of $218 thousand, $289 thousand, $186 thousand and $313 thousand, respectively. Pursuant to a request to the Veterans' Administration for clarification of the figures I determined the reason for the apparent discrepancy between my numbers and the numbers you cited. The figures on bed costs for Loma Linda, Augusta and the Bronx were indexed up to December 1984 and the bed cost figure for the Houston project was indexed down to December 1984. The bed cost figures were indexed in order to provide a more accurate comparison between the hospitals that were completed in the past and the Houston project which has not been constructed.

The Veterans' Administration has provided me with different bed cost numbers for Houston, Loma Linda, Augusta and the Bronx. The new figures for Houston, Loma Linda, Augusta and the Bronx have been indexed up to 1986 when construction on the Houston project is scheduled to begin. Utilizing the new calculation the bed costs for Houston, Loma Linda, Augusta and the Bronx would be $241 thousand, $319 thousand, $206 thousand and $346 thousand, respectively. I still find that the bed cost of the Houston VA hospital project compares favorably with the bed-costs of the other hospitals.

I hope that the clarification that I have provided will be useful to you in your deliberations on the future of the Houston VA hospital replacement project. I reiterate my desire that the Veterans' Affairs Committee not consider any proposal that would result in further delay of completion of the Houston project.

Sincerely,

Lloyd

Lloyd Bentsen

Chairman Murkowski. I assume that you would support a strict cost control application of design and bid bond contract and to try to ensure that if this hospital goes into the next stage, which is a three-stage commitment, that we could ensure that there are not going to be substantial change orders.

Senator Bentsen. Mr. Chairman, that is what I am here fighting for. I want to see us proceed with this hospital without substantial design change orders. And I would support that throughout the process. One of the problems we run into, whether we are talking about Government buildings or we are talking about defense contracts, is continued change orders. And I would like to see it stabilized and constructed expeditiously.

Senator Gramm. Mr. Chairman, if I might add to that, I think one view that Senator Bentsen and I clearly share is the belief that given the flatness of the market, and its impact on Houston, and given the number of people in the construction industry who are starving for projects, we could build a 1,047-bed facility, on which we have already paid for engineering and design work, cheaper today than you could build a 750-bed facility 2 or 3 years from now.

And also, I return to the point that this is the flagship VA hospital in our region of the country. It is in the midst of and, in fact, part of one of the largest and most sophisticated medical centers in the world. And the advantage we have with this facility is that if there are found to be in the future excess capacities in other hospitals in the region we can provide quality care, intensive care, specified specific treatment in this facility that we probably cannot provide anywhere else in the region.

Finally, let me just inject one additional point about the cost of the beds. This hospital will, of course, have a very large outpatient facility. We hope to house the regional Veterans' Administration also in this building. And so when you are talking about hospital beds I guess the question is how do you allocate the space and the costs that go into the outpatient clinic and into the other facilities that are not directly related to the inpatient care and the operation of the hospital bed? My guess is that is where the discrepancy in the figures can be found.

Chairman **Murkowski**. I have been provided with figures that indicate the daily vacancy in Houston to be 5,410 beds vacant per day in the private sector. I am wondering if the private sector has taken any position toward the proposed Houston VA Hospital? Is it a controversial issue? Does the private sector believe that the VA has an obligation to utilize existing beds before building additional ones or have they expressed any interest at all in the proposed facility?

Senator **Bentsen**. Mr. Chairman, to the best of my knowledge, I have received not one objection to the construction of this hospital from the other hospitals throughout the area.

Senator **Gramm**. No; so far as I am aware there has been no objection, no opposition. I think that there is a belief in Texas and nationwide that we are committed to an independent VA hospital system and that there is really no relationship between whatever excess beds exist in a major national and world medical center and facilities we need to provide VA care in Houston.

Chairman **Murkowski**. Senator Cranston, ranking minority member of the committee.

Senator **Cranston**. Yes; I do not have any questions or statements on the subject at this time. I am very sympathetic with the concerns of the Senators from Texas, and I hope we can resolve it in a reasonable way.

Senator **Bentsen**. Thank you, Mr. Chairman.

Chairman **Murkowski**. As I am sure you are aware this would be a Davis-Bacon project. So the prevailing base would be applicable.

Our next panel are the representatives of the Veterans' Administration. I welcome Dr. John Gronvall, Deputy Chief Medical Director, who will be accompanied by Mr. Richard Falco, Acting Director, Facility Engineering, Planning and Construction Office, and Ms. Susan Livingstone, Associate Deputy Administrator of Logistics. We welcome you to this morning's hearings.

And I think Senator Cranston, who is on a tight schedule would like to proceed with some questions now. Therefore, we will change the procedure and let him begin. That is one of the prerogatives we have around here.

Senator **Cranston**. Yes.

I thank you very much for your cooperation. All three of the committees I serve on are meeting today and at least two of those that the chairman serves on are meeting today, and we have difficulties meeting our obligations.

I will dispense with an opening. I had one prepared and ask that it appear in the record as if read.

[The prepared statement of Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follows:]

PREPARED STATEMENT OF HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

GOOD MORNING AND WELCOME. THIS OUR SECOND DAY OF HEARINGS ON MATTERS RELATING TO THE CONSTRUCTION OF V.A. MEDICAL FACILITIES. DURING YESTERDAY'S HEARING WE DISCUSSED V.A. MEDICAL POLICIES RELATED TO CONSTRUCTION. TODAY, WE WILL BE LOOKING PRINCIPALLY AT THE CONSTRUCTION PLANNING PROCESS AND THE PROPOSED CONSTRUCTION PROJECTS AT SPECIFIC SITES.

MR. CHAIRMAN, I INTEND TO BE VERY BRIEF THIS MORNING AND WON'T REITERATE ALL THE CONCERNS I EXPRESSED YESTERDAY.

I DO, HOWEVER, WANT TO STRESS ONE POINT AGAIN: THAT IS MY VERY STRONG CONVICTION THAT, GIVEN THE TREMENDOUS COMPETITION FOR SCARCE FEDERAL RESOURCES, THE V.A. IS PROPOSING TO UNDERTAKE MAJOR REPLACEMENT AND MODERNIZATION PROJECTS THAT ARE TOO LARGE. MAKING LARGER-THAN-NECESSARY INVESTMENTS IN A RELATIVELY FEW PROJECTS OVER THE NEXT FEW YEARS WILL BE UNWISE IF SUCH ACTIONS DELAY -- AS THEY MUST -- OTHER CONSTRUCTION PROJECTS WHICH ARE NEEDED BUT WILL GO UNFUNDED. BY DISTRIBUTING V.A. CONSTRUCTION FUNDS MORE EQUITABLY THROUGHOUT THE NATION AND PROCEEDING WITH GREATER NUMBERS OF MEDIUM-SIZED FACILITIES, WE CAN HELP MORE VETERANS MORE FAIRLY.

THUS, I HAVE VERY RECENTLY AGAIN URGED THE V.A. TO REEXAMINE ITS MAJOR REPLACEMENT AND MODERNIZATION BED-SIZING CRITERIA. I CONTINUE TO BELIEVE THAT THE APPROACH UNANIMOUSLY ADOPTED BY THE COMMITTEE LAST MAY IS THE DIRECTION IN WHICH WE SHOULD BE HEADING. I AM NOT TIED -- AND I WANT TO MAKE THIS VERY CLEAR -- I AM NOT TIED TO ANY GIVEN BED-SIZING FORMULA. HOWEVER, I BELIEVE STRONGLY THAT ANY BED-SIZING FORMULA MUST BE WEIGHTED SO AS TO REFLECT APPROPRIATE PRIORITIES FOR THE TREATMENT OF SERVICE-CONNECTED DISABLED VETERANS AND FINANCIALLY-NEEDY VETERANS.

MR. CHAIRMAN, I ASK UNANIMOUS CONSENT THAT THERE BE PRINTED IN THE RECORD AT THIS POINT MY MARCH 18 LETTER TO THE ADMINISTRATOR REGARDING THE HOUSTON PROJECT, THE COMMITTEE'S MAY 24, 1984, CONSTRUCTION AUTHORIZATION RESOLUTION AND STATEMENT OF VIEWS, AND AN EXCERPT REGARDING CONSTRUCTION FROM THE MARCH 6, 1985, LETTER FROM THE DEMOCRATIC MEMBERS OF THIS COMMITTEE TO THE BUDGET COMMITTEE.

[THE LETTERS AND EXCERPTS REFERRED TO ABOVE FOLLOW:]

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 6, 1985

Honorable Pete V. Domenici
Chairman
Honorable Lawton Chiles
Ranking Minority Member
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Pete and Lawton,

We are writing to provide you with the views of the Democratic membership of the Committee on Veterans' Affairs with respect to the FY 1986 budget for veterans' programs within the jurisdiction of our Committee.

We have very carefully reviewed the Administration's fiscal year 1986 budget for veterans' programs and the testimony of representatives of the Veterans' Administration, the Department of Labor, and veterans' service organizations at our February 20 hearing. In addition, we have given great weight to the urgent need to control federal spending in order to reduce the projected rapidly increasing federal deficits. However, we also strongly believe that deficit-reduction efforts must be undertaken in a manner that is fair to our Nation's veterans and consistent with our obligations to those who have served and made such great sacrifices to keep our Nation free and strong.

We have taken the unusual step of submitting a separate statement of the views of the Democratic membership of the Committee because our very best efforts to reach an accord with the majority membership were, we regret, unavailing.

GOVERNMENT-WIDE CONSIDERATIONS

- Agency-by-Agency Freeze. Before focusing on specific items, we would like to state that, if the Congress commits itself to a government-wide spending freeze -- in the form of FY 1985 appropriations-level (or outlay-level) caps for each department and agency, the Veterans' Administration should be included. However, in light of the high priority that properly attaches to veterans' programs, we believe strongly that these programs must not be singled out for discriminatory cuts in order to make room for increases in other budget areas.

* * * * * * *

reduction in the medical care account for any such revenue and with the amount of expected receipts not allocated to either Appropriations Committee under the budget resolution conference report cross-walk; and (2) providing the VA with whatever FTEE and associated resources would be necessary to implement such a program. (Preliminarily, in our view, such requirements would be at least 350 FTEE and $7 million.) Without such safeguards, enactment of a health insurance reimbursement program would have the very real potential of reducing the VA's capacity to provide health care to eligible veterans, a result that we believe would be totally unsupportable.

(Our recommendation is $25.0 million in budget authority and $36.9 million in outlays over baseline.)

- Medical and Prosthetic Research. Add $5.3 million in both budget authority and outlays to the medical and prosthetic research account in order to support 222 FTEE over the level proposed by the President for VA medical and prosthetic research projects.

These additional funds would allow the VA to retain in FY 1986 the same dollar level proposed by the Administration to be available for research efforts for FY 1985. Also, this level would restore 65 FTEE for which funds were appropriated in the FY 1985 HUD-Independent Agencies Appropriations Act but which the VA is not using as well as avoid the further, 157 FTEE reduction proposed in the FY 1986 budget. The VA's failure to utilize the 65 FTEE is similar to the situation discussed earlier in the medical care account and our analysis of the action under this account is the same as, of course, is our opposition to the application of a 5-percent federal pay cut. We are convinced that investments in the VA medical and prosthetic research program pay significant dividends in terms of improvements in the quality of care for America's veterans and do not believe that these programs should suffer the arbitrary reductions proposed by the President from the activity level underway at present. Such reductions would not only reduce future research activity but would have great potential for causing significant disruptions in ongoing research efforts. For these reasons, we urge this modest addition.

(Our recommendation is $7.8 million in budget authority and $5.5 million in outlays less than baseline.)

- Construction. With respect to the VA's medical construction program, we recommend the levels set forth in the VA's budget. We stress, however, that this should not be taken as an indication of our endorsement or approval of any or all of the specific plans for VA construction in fiscal year 1986. The Committee will address the specifics regarding individual projects at the appropriate time through this Committee's major construction project-approval process under section 5004 of title 38, United States Code.

We note, nevertheless, that we are deeply concerned by the Administration's total disregard of our Committee's positions, taken last May in that process, that a bedsizing model for major replacement/modernization projects be developed that emphasizes care for veterans with service-connected disabilities or in receipt of VA pension and that no facilities be constructed with over 700 hospital beds. We intend to continue to pursue this matter with the VA and through the section 5004 Committee-approval process, as well as through the appropriations process and, if necessary, through legislation.

Although at this time we have made no allocation among the three major replacement/modernization projects included in the President's budget -- at Houston, Mountain Home, and Philadelphia -- we do support substantially greater funding than requested by the President for the Philadelphia project for FY 1986 and the appropriation of $6 million for updating the 10-year-old design for a replacement hospital in Baltimore. Also, consistent with the Committee's approval of construction funding last year based on downsizing factors, we continue to believe that projects of over 700 hospital beds are too large, and, in the appropriations process this year (and in subsequent years), we will propose and pursue an amendment to prohibit the use of funds for the construction of any VA medical facility with over 700 hospital beds. Under this approach, the funds for updating Baltimore's design, any resizing, and the reallocation of more funding to Philadelphia than is proposed would all be accomplished within the total amount requested by the President for construction (major and minor combined). However, we will urge the VA to use its working reserve fund to begin immediately any resizing and redesign efforts so that scheduled construction could move forward in FY 1986.

With respect to non-medical construction, we note that the President's budget proposes the appropriation of $6 million for the purposes of land acquisition for a new national cemetery in Northern California. We strongly support the establishment of a new national cemetery there but cannot agree to any expenditure to purchase the land given the fact that there is a parcel of land in Santa Nella/Los Banos, California, that is available to the VA at no cost to the Federal Government for the purposes of a new cemetery. Thus, we support the appropriation of $6 million for a new cemetery but only for the purposes of site preparation and start-up costs associated with establishing it at the Santa Nella/Los Banos site. We note that not only is this a considerably more cost-effective approach but that it would also mean that the new cemetery could be made available considerably sooner to meet the needs of Northern California veterans and their families and that this approach has the support of all the major California veterans' service organizations.

(Our recommendation is $182.2 million in budget authority and $6.5 million in outlays below baseline.)

- Grants for construction of State extended care facilities.

Our recommendation is the same in both budget authority and outlays as the President's budget as reestimated by CBO.

(This is $13.6 million in budget authority below baseline and the same as baseline in outlays.)

* * * * * * *

(Our recommendation under the conditions discussed above would be up to $50 million in budget authority and outlays below baseline.)

FUNCTION 500

With regard to the Function 500 accounts for veterans' employment programs designed specifically to assist veterans in finding suitable employment in order that they may become productive participants in the society they fought to maintain, we are in agreement with the President's fiscal year 1986 request except, as previously noted, with respect to the proposed 5-percent federal pay cut.

REVENUES

We want to express our firm opposition to the enactment of any legislation that would subject VA service-connected disability compensation to the federal income tax, as has been proposed in the Department of the Treasury's tax reform and simplification package. We believe that such a proposal would produce an inequitable, unjust, and totally unacceptable result. Specific reasons for our opposition to that proposal are outlined in the preamble of S. Con. Res. 20 (copy enclosed), of which we are all cosponsors, a resolution to express the sense of the Congress that VA compensation should remain tax exempt. We urge the Committee not to include any increased revenues that could be achieved from such a proposal and note that enactment of any such proposal would inevitably lead to the consideration of increases in the benefit rates, in order to restore the real value of the payments, which could consume any revenues raised by taxing the benefits.

* * * * *

We wish to emphasize that we have arrived at our recommendations after a thorough review of veterans' programs and extensive efforts to identify areas in which savings and economies could be achieved consistent with the Congress' continuing commitment to meet its obligations to the Nation's veterans and their survivors, and particularly to service-connected disabled veterans.

These views reflect our best judgment as of this date. If we or the Committee's minority staff may be of further assistance in your consideration of this letter, please feel free to call upon us.

Sincerely,

Spark M Matsunaga
Spark M. Matsunaga

Alan Cranston
Ranking Minority Member

Dennis
Dennis DeConcini

George Mitchell
George J. Mitchell

Jay Rockefeller
John D. Rockefeller IV

Enclosures

cc: All Budget Committee Members

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 18, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

I am writing on a matter of urgent concern to me regarding the VA's construction of major replacement/modernization projects and, specifically, the major projects scheduled to receive construction funding in FY 1986: Houston, Texas; Philadelphia, Pennsylvania; and Mountain Home, Tennessee.

As you'll recall, last May the Senate Veterans' Affairs Committee approved these and other VA medical construction projects with hospital bed-sizes that were less than the VA had proposed and that corresponded appropriately to the needs of service-connected-disabled veterans and financially needy veterans. It is my position that the VA should now proceed in the most expeditious fashion with construction on these three projects in a manner that is consistent with the views of the Committee as they were expressed in the statement of views (a copy is enclosed) accompanying its resolution, dated May 24, 1984, providing for a Houston replacement facility of approximately 685 hospital beds, a Philadelphia facility of approximately 369 hospital beds, and a Mountain Home facility of approximately 387 hospital beds (these figures do not include any nursing-home beds planned for those facilities).

In this regard, I urge you to proceed immediately to take all steps necessary to permit construction in Houston, Philadelphia, and Mountain Home to proceed in a manner consistent with this approach at the earliest possible time during FY 1986. I note that since the only construction activities scheduled to begin during FY 1986 in Philadelphia are the nursing-home-care unit, pedestrian bridge, and parking lot, hospital-bed resizing should produce no delay in completing that project. In the cases of the other two projects, available funds in the VA's major construction account working reserve, or any other available funds, should be used now for revising the preliminary plans for the projects so that working drawings can be accomplished which will reflect the revised size of the projects and the projects will not be delayed to any significant extent.

I believe that if the VA undertakes these revisions as a top priority, the planning for these projects could be redone quickly. DM&S has advised that its normal process of review, dispute resolution, and appeal would require at least seven months merely to make the specific downsizing decisions. I believe that if the key people from the VAMC were brought to Central Office to work with DM&S and Office of Construction officials and all met together, the basic decisions could be made expeditiously. Independent A&L firms have advised that it is possible for redesign of the preliminary plans to be done in 3-6 months if there is maximum cooperation. Moreover, any delays thus encountered during the planning stages could be further minimized thereafter since smaller facilities should take less time for working drawings to be completed, to be constructed, and to be made operational. Ultimately, therefore, it would appear to me that the projects could be completed within periods of time close to the current schedule.

What is needed is a "can do" rather than a "can't do" approach.

With respect to the Houston facility specifically, I note that I have been advised by a number of persons with extensive experience in hospital management, including former Chief Medical Director Dr. Donald L. Custis, that any facility bigger than 700 hospital beds presents severe management problems. My 16 years' experience with the operation of the 1,100-bed VAMC at Long Beach, California, confirms that position.

Moreover, I trust that it is not the contention that 700 hospital beds is too few to facilitate the operation of the hospital efficiently and effectively in order to to provide care for the 8.4 percent of that facility's patients being treated for service-connected conditions and the additional 12.4 percent who have service-connected conditions but are receiving care for a non-service-connected condition.

The same analysis applies to the other six facilities, none of which has a service-connected inpatient caseload (combining these two categories) of over 40 percent. In fact, the combined service-connected caseloads at all but the Allen Park and Augusta facilities do not exceed 26 percent, considerably below the VA system-wide service-connected average of about 30 percent. Further, the percentage of patients at these five facilities who have no service-connected disability or do not receive VA pension averages well over 55 percent. So it is clear that generally well over half the beds proposed for each facility are being proposed for the care of non-service-connected veterans who may not be financially needy. (The above figures -- provided by the VA for last year's construction resolution -- are the most current available to us.)

Given the pressing need to curb Federal spending -- both now and in the future -- in order to reduce the projected deficits, I believe it is imperative that the VA develop an approach to sizing hospitals that seeks to allocate scarce funding over a greater number of projects in order more equitably to serve veterans across the Nation. Such a reallocation approach, stressing service-connected and pension-eligible veteran care, should be undertaken both with respect to these three projects as well as the other four that the Committee approved last year (Allen Park, Augusta, New York, and Baltimore) in a manner that reflects the Committee's position on the sizes of these proposed facilities.

I would appreciate your personal and prompt attention to this request.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

cc: Honorable Frank H. Murkowski
Honorable Jake Garn
Honorable Patrick J. Leahy
Honorable Lloyd Bentsen
Honorable Phil Gramm
Dr. John W. Ditzler

ALAN K. SIMPSON, WYO., CHAIRMAN

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DENNIS DECONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

May 24, 1984

Honorable Howard Baker
Majority Leader
The United States Senate
Washington, D.C. 20510

Dear Mr. Majority Leader:

Pursuant to section 5004(a) of title 38, United States Code, the Senate Committee on Veterans' Affairs has adopted the enclosed resolution by a poll of its members completed today, May 24 , 1984. The resolution approves 55 Veterans' Administration medical facility construction projects, working drawings for three projects, and one medical facility lease. In the listing attached to the resolution and incorporated by reference therein, the projects are identified and their estimated costs and, as to seven replacement/ modernization projects, maximum bedsizes are indicated.

With the exception of the five FY 1985 Administration-proposed replacement/modernization projects, the Committee, in approving Administration-proposed projects, has approved them at the proposed size and Administration cost estimate. However, the Committee has reallocated the total resources for the five replacement/modernization projects in a way that is more equitable and responsive to statutory priorities for care for service-connected-disabled veterans. The result is that the Committee resolution reduces the bedsizes and estimated costs for each of those five projects and, within the overall level of the total estimated costs for them ($784 million), approves two additional projects, one in Philadelphia and one in Baltimore. In the case of each replacement or replacement/modernization project, the Committee notes that its approval is for a facility to replace the existing facility. (Enclosed with the resolution is a statement of Committee Views regarding this reallocation).

The Committee has acted favorably on the VA's request for Committee approval for working drawings for two projects in fiscal year 1985 (Durham, North Carolina, and Knoxville, Tennessee) and one project in fiscal year 1984 (Tampa, Florida). However, the Committee also believes that, under the authority provided in section 211 of Public Law 98-233, this Committee's approval would not be required if "working reserve" funds in the VA's major construction account were used for the working-drawing phase for these projects.

With warm regards,

Sincerely,

Al Simpson
ALAN K. SIMPSON
Chairman

Alan Cranston
ALAN CRANSTON
Ranking Minority Member

Enclosures

CC: Honorable Mark O. Hatfield
Honorable John C. Stennis
Honorable Jack Garn
Honorable Walter D. Huddleston
Honorable Harry N. Walters

ALAN K. SIMPSON, WYO., CHAIRMAN

STROM THURMOND, S.C.
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DENNIS DE CONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

May 24, 1984

Honorable Thomas P. O'Neill, Jr.
Speaker
House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Pursuant to section 5004(a) of title 38, United States Code, the Senate Committee on Veterans' Affairs has adopted the enclosed resolution by a poll of its members completed today, May 24 , 1984. The resolution approves 55 Veterans' Administration medical facility construction projects, working drawings for three projects, and one medical facility lease. In the listing attached to the resolution and incorporated by reference therein, the projects are identified and their estimated costs and, as to seven replacement/ modernization projects, maximum bedsizes are indicated.

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With warm regards,

Sincerely,

Al Simpson

ALAN K. SIMPSON
Chairman

Alan Cranston

ALAN CRANSTON
Ranking Minority Member

Enclosures

CC: Honorable G.V. "Sonny" Montgomery
Honorable John Paul Hammerschmidt
Honorable Jamie L. Whitten
Honorable Silvio O. Conte
Honorable Edward P. Boland
Honorable Bill Green

ALAN K. SIMPSON, WYO., CHAIRMAN
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GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

RESOLUTION OF THE COMMITTEE ON VETERANS' AFFAIRS

United States Senate

RESOLVED BY THE COMMITTEE ON VETERANS' AFFAIRS OF THE UNITED STATES SENATE, pursuant to section 5004(a) of title 38, United States Code, that the major medical construction projects specified in the attached listing are approved at the fiscal year 1985 estimated costs, bedsizes, and total estimated costs shown.

Al Simpson
ALAN K. SIMPSON
Chairman

Alan Cranston
ALAN CRANSTON
Ranking Minority Member

Adopted: May 24, 1984

APPROVED BY SENATE COMMITTEE ON VETERANS' AFFAIRS
RESOLUTION DATED MAY 2 , 1984

[in thousands of dollars]

Location	Description	Fiscal Year 1985 Approval (Max. Bedsize)	Fiscal Year 1985 Approval (Estimated Cost)	Total Estimated Cost
A. Replacement and modernization				
Allen Park, MI	Replacement and modernization (Site acquisition and preparation)	571*	$ 8,000	$184,400
Augusta (Lenwood), GA	Replacement Medical Center (Design and site preparation)	750*	11,500	94,000
Baltimore, MD	Replacement Medical Center (Revision of design and site preparation)	325	6,500	88,800
Houston, TX	Replacement and modernization (Design and site preparation)	805*	19,700	195,600
Mountain Home, TN	Bed Towers and Renovation (Design, site preparation, and temporary buildings and allocation)	387	8,700	47,100
New York, NY	Outpatient and Clinical Addition and Alterations (Design and phase I of construction)	646	11,500	70,600
Philadelphia, PA	Clinical Addition, Renovation and 120-bed Nursing Home Care Unit (Design and site preparation)	489*	10,500	103,300
Subtotal, replacement and modernization		3,973**	$76,400	$783,800

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*Includes 120 nursing home care beds
**Includes 480 nursing home care beds

APPROVED BY SENATE COMMITTEE ON VETERANS' AFFAIRS
RESOLUTION DATED MAY 2 , 1984

[in thousands of dollars]

Location	Project Description	Prior Approval by Committee	Fiscal Year 1985 Approval	Total Estimated Cost
B. Other				
Albany, NY	Modify Wards	-	$25,200	$25,200
Alexandria, LA	Clinical Improvements	-	26,900	26,900
Alexandria, LA	120-Bed Nursing Home Care Unit	-	5,400	5,400
Amarillo, TX	Addition and Renovation of Clinical Support	-	22,000	22,000
American Lake, WA	Laundry Replacement	-	4,400	4,400
Big Spring, TX	Electrical Distribution System	-	2,200	2,200
Boise, ID	Geothermal Conversion	-	4,500	4,500
Boston, MA	Fire and Safety Improvements: Sprinklers	-	4,300	4,300
Brockton, MA	Renovate Building 8 for Patient Privacy, Fire and Safety, and Seismic	-	4,400	4,400
Brockton (West Roxbury), MA	Outpatient Addition, Research and Education, Administration	-	42,800	42,800
Buffalo, NY	Research Building and Clinical Expansion	-	16,300	16,300
Cheyenne, WY	Expand and Renovate Building 1 for Clinical Functions	-	14,600	14,600

Location	Project Description	Prior Approval by Committee	Fiscal Year 1985 Approval	Total Estimated Cost
Chillicothe, OH	Renovate Building 1 (Modernization Phase III)	-	$ 4,300	$ 4,300
Clarksburg, WV	Clinical Addition and Alterations	-	21,600	21,600
Coatesville, PA	Fire and Safety Improvements	-	11,700	11,700
Dallas, TX	Upgrade Primary Electrical Distribution System	-	3,200	3,200
Danville, IL	Renovate Building 14 for Administration	-	2,800	2,800
Durham, NC	Clinical Addition	-	29,400	29,400
Durham, NC	120-Bed Nursing Home Care Unit, Research, Administration, and Geriatric Research Education and Clinical Center	-	8,800	8,800
Fresno, CA	Clinical Addition	-	6,300	6,300
Grand Island, NE	Fire and Safety Improvement, Air Conditioning, Patient Privacy and Support Systems	-	5,900	5,900
Grand Junction, CO	Outpatient and Clinical Addition	-	12,100	12,100
Hampton, VA	Fire and Safety Improvements	-	5,700	5,700
Hines, IL	40-Bed Long-Term Spinal Cord Injury Building	-	5,800	5,800
Iowa City, IA	Ambulatory Care and Clinical Addition	-	20,800	20,800
Lexington (Cooper Drive), KY	Clinical Addition	-	32,000	32,000

Location	Project Description	Prior Approval by Committee	Fiscal Year 1985 Approval	Total Estimated Cost
Long Beach, CA	160-Bed Spinal Cord Injury Unit and Spinal Cord Injury Outpatient Clinic	-	$23,000	$23,000
Long Beach, CA	Construct Supply Warehouse	-	3,800	3,800
Los Angeles, CA	Outpatient Clinic Building	3,000	47,800	50,800
Louisville, KY	Clinical and Education Addition	-	12,500	12,500
Lyons, NJ	Fire and Safety Improvements	-	13,300	13,300
Lyons, NJ	Renovate Building 4 for Intermediate Care	-	3,900	3,900
Marion, IL	Seismic Corrections	-	5,700	5,700
Murfreesboro, TN	120-Bed Nursing Home Care Unit	-	5,600	5,600
Omaha, NE	Electrical, Fire and Safety Corrections	-	5,500	5,500
Palo Alto (Palo Alto Div.), CA	Spinal Cord Injury Addition	-	15,200	15,200
Pittsburgh (Highland Drive), PA	Modernize HVAC, Fire and Smoke Detectors, Secondary Electrical System	-	32,200	32,200
Pittsburgh (University Drive), PA	Patient Addition	24,500	4,200*	28,700
Prescott, AZ	120-Bed Nursing Home Care Unit	-	8,300	8,300
San Francisco, CA	120-Bed Nursing Home Care Unit and Parking Garage	14,700	3,000	17,700
Sheridan, WY	Outpatient Clinic Addition		10,400	10,400

Location	Project Description	Prior Approval by Committee	Fiscal Year 1985 Approval	Total Estimated Cost
Shreveport, LA	Ambulatory Care Addition and Linear Accelerator	-	$ 6,200	$ 6,200
Shreveport, LA	Upgrade Primary Distribution System and Elevators	-	4,300	4,300
St. Louis (Jefferson Barracks), MO	Laundry Replacement	-	3,800	3,800
Tampa, FL	Radiation Therapy	-	4,200	4,200
Topeka, KS	Electrical Corrections, Primary and Secondary	-	8,200	8,200
West Los Angeles, CA	117-Bed Nursing Home Care Conversion	-	5,500	5,500
West Los Angeles, CA	Renovate Buildings for Domiciliary	-	11,700	11,700
Subtotal, other		$42,200	$581,700	$623,900
TOTAL		$42,200	$658,100	$1,407,700

Veterans' Administration Lease Proposal Approved by Senate Committee on Veterans' Affairs Resolution Dated May 2 , 1984

Location	Project Description	Estimated Annual Rental
Pensacola, FL	Outpatient Clinic	$522,800 - $606,500

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*Change in scope of project to be funded from reprogrammed funds.

VETERANS' ADMINISTRATION CONSTRUCTION PROJECTS APPROVED FOR IN-HOUSE WORKING DRAWINGS BY THE SENATE COMMITTEE ON VETERANS' AFFAIRS RESOLUTION DATED MAY 2 , 1984

Location	Project Description
Durham, NC	Boiler Plant Replacement
Knoxville, TN	Fire and Safety Improvements
Tampa, FL	Radiation Therapy

*Approval encompasses only working drawings and is limited to a total of $350,000 for all three projects.

Senate Committee on Veterans' Affairs
Views on Approval of
FY 1985 VA Replacement/Modernization
Construction Projects

After reviewing agency responses to Committee requests for information about and explanations of the assumptions, processes, and justifications for the array of medical facility construction projects for which the Veterans' Administration requests funding each year, the Committee continues to be very concerned about current policies used for determining the need for and size of the facilities proposed for construction. Essentially, the VA bases its planning on the demographics of the entire veteran population in the area to be served. However, it does not take into account relative statutory priorities, especially as they relate to the needs of veterans with service-connected disabilties.

In light of the large potential demand for care from service-connected-disabled and other priority groups within the fast-growing population of older veterans, it is essential that the implications of current practice be evaluated. Present decisions regarding allocations of medical-facility construction dollars represent not only very large expenditures in the near term ($1.4 billion in total estimated costs for projects proposed for at least partial funding in FY 1985) but will also have a marked influence on the VA's capacity to provide care over the next two to three decades.

In its review of the Administration's proposals for five replacement/modernization projects, the Committee was concerned about the rationale for inclusion and exclusion of particular projects in the replacement/modernization category. After analysis of information and testimony received by the Committee, no clear priority determinations or planning criteria and goals were discernible which would explain the inclusion of the five projects and the exclusion of two projects, in Philadelphia and Baltimore (which the VA had included in its submission to the Office of Management and Budget), in establishing the VA's budget request for FY 1985. Thus, the Committee, in adding two replacement/modernization proposals, has structured its approvals in a way that would reflect the Committee's and the Congress' long-standing emphasis on ensuring a comprehensive hospital system for service-connected disabled veterans and the Committee's interest in developing an approach that would permit scarce resources to be distributed so as to provide for more equitable access by veterans to better quality health care.

To achieve this result, the Committee devised a model for reallocating the aggregate level of the VA's FY 1985 appropriations requests for replacement/modernization projects ($78 million), the total estimated costs for these projects ($784 million), and the approximate total of the hospital bed levels proposed for these projects (3384 beds). The model (described in detail below) that the Committee developed emphasizes the statutory priority to be accorded to veterans receiving care for service-connected disabilities.

Description of Model:

The model developed to achieve an improved allocation of funding and hospital bed numbers for replacement/modernization projects uses (1) VA hospital census data (agencywide and for the existing seven facilities) showing the percentages of hospitalized veterans who are service-connected disabled veterans receiving care for their service-connected disabilities (SCSC) or for non-service-connected disabilities (SCNSC) and those who are in receipt of VA need-based pension (PEN), (2) VA hospital occupancy-rate data, and (3) the Administration-proposed number of hospital beds for each new facility (the nursing home beds proposed in four of the projects were excluded from the calculations). These data were then given various weights and incorporated into a model to determine approved hospital bedsizes. Service-connected disabled veterans receiving care for a service-connected disability were accorded twice the weight of service-connected disabled veterans receiving care for a non-service-connected disability. Together, these service-connected categories were accorded twice the weight of veterans receiving care who were in receipt of VA pension benefits (used as a measure of the care provided to eligible needy veterans). The resulting calculation for each facility was then adjusted by the agency-wide calculation of these factors and multiplied by the Administration-proposed bedsize. Finally, that product was adjusted to take into account the relative intensity of utilization as shown in occupancy rates for the existing facilities. This final calculation produced the bedsize approved by the Committee as the maximum bedsize for the proposed project.

The following is a mathematical description of the model:

$$\left(\frac{2(2 \times SCSC_i + 1 \times SCNSC_i) + 1 \times PEN_i}{2(2 \times SCSC_j + 1 \times SCNSC_j) + 1 \times PEN_j} \times \text{Administration-proposed bedsize}_i \right) \times \frac{OR_i}{OR_k} = \text{Approved bedsize}_i$$

OR = occupancy rate
i = individual facility
j = VA agencywide
k = average of 7 facilities

Values for SCSC, SCNSC, PEN, OR, and Administration-proposed bedsizes for each project are shown in the attached chart.

HOSPITAL BEDSIZING DATA

Facility	Percentage SC SC	Percentage SCNSC	Percentage PEN	Percentage Neither SC nor PEN	Occupancy Rate (%)	No. of existing beds	VA-proposed bedsize/est. cost ***	Committee-approved hospital bedsize/est. cost ***
Allen Park	15.4	14.6	19.4	49.4	73.3	539	521/ $232	451/ $184.4
Augusta	31.0	9.3	20.7	39.0	84.4	722	630/ $102.4	630/ $94
Houston	8.4	12.4	22.9	56.2	85.4	1,018	919/ $286	685/ $195.6
Mountain Home	8.1	11.6	31.3	49.0	78.3	510	530/ $70.3	387/ $47.1
New York	8.2	17.5	26.2	48.0	81.6	1,030	784/ $93.3	646/ $70.6
Philadelphia	12.5	3.0	23.9	60.6	80.0	479	(538/ $147.6)*	369/ $103.3
Baltimore	7.1	7.1	24.0	61.8	80.1	291	(400/ $119.8)*	325/ $88.8
VA-Wide	16.1	13.8	23.8	45.9	79.2	---	---	---
					TOTALS:	4,627	3,384/ $784 (4,322/ $1,051.4)**	3,493/ $783.8

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* Not proposed in FY 85 budget; bedsize and dollar amount included in VA draft prospectus provided to Committee.
** Includes projects not proposed in FY 85 budget.
*** In millions of dollars.

ASSUMPTIONS:

(1) Minimum hospital size is 325 (affects Baltimore).
(2) Maximum hospital size is that presently proposed by VA (affects Augusta).
(3) Nursing home care beds subtracted from calculations (affects Allen Park (120), Augusta (120), Houston (120), and Philadelphia (120)).

FINALLY, MR. CHAIRMAN, I WANT TO THANK YOU FOR THE NICE COMMENTS THAT I UNDERSTAND YOU MADE, AT THE CLOSE OF YESTERDAY'S HEARING, ABOUT MY REMARKS YESTERDAY REGARDING THE SEVERE BUDGET CONSTRAINTS CONFRONTING ALL OF US. ALTHOUGH WE MAY NOT AGREE ON ALL THINGS, WE SURELY AGREE ON THE SERIOUSNESS OF OUR ECONOMIC PLIGHT.

Senator **Cranston**. I would like to go directly to some questions.

First of all, on the matter of the Texas hospital that we have been hearing about, I would like to ask you, Dr. Gronvall, about the allegations that there would be such a tremendously long delay if the institution were to be downsized. I cannot understand how it could take the long time that has been suggested to revise those plans and proceed with a lesser sized institution that would be more in keeping with the apparent real needs.

We have had some statements by experts in the field who indicate that it should be possible to revise those plans within 3 to 6 months and get going and, thus, not have any significant delay. I would like to hear an explanation of why that is not possible.

Dr. **Gronvall**. We would be pleased to, Senator Cranston. Let me ask Susan Livingstone to comment on the steps that we would have to go through if we significantly downsized the hospital and what would be required in revisiting the plans and the relationships of various elements, of beds, and supporting elements in the hospital.

Ms. **Livingstone** Thank you.

Senator Cranston, we estimate that the additional time that would be required—and I know the VA has provided figures—would range up to about 36 months.

Senator **Cranston**. It would be 36 months?

Ms. **Livingstone**. That is correct, sir.

Senator **Cranston**. I cannot comprehend that timespan.

Ms. **Livingstone**. What basically would occur on the downsize of Houston to the degree which has been presented to the Veterans' Administration is that the VA would have to go back to the very beginning of conceptual development of the project. The Department of Medicine and Surgery would have to make determinations, based on the new bed sizing, if there should be significant changes in the services and types of beds that are going to be offered. That decisionmaking takes time. There should be coordination with the medical center and the field planning activities as well.

Once those decisions are made, then we need to go back and reassess the workloads and data packages we would use to develop the new conceptual design solutions. We do have a selected design solution now for a 1,047-bed level. If you go to a 600- or 700-bed hospital, the design would be totally different.

So it basically is not just taking off, for instance, a wing or a floor of the current design. We would have to totally redesign.

Senator **Cranston**. Well, I would think you could bring in the various people that would play various parts of that, put them in one place for a week and resolve those questions.

This is the most absurd statement of bureaucratic delay and consequent expense to taxpayers that I have heard of recently.

Ms. LIVINGSTONE. The programing decisions within the Department, I am sure, could be fast tracked, sir, in terms of going back and determining what services to remove. The major delay discussed here is in the design solution. And basically, the preliminary plan design, which was done by a contracted A/E and not by the VA, took 13 months alone for the current hospital. We would have to go back and reperform those plans for the new design configuration.

Senator CRANSTON. You have done most of that siting work already.

I was around here during World War II when the Pentagon was built, the largest building around here. And that was done very, very swiftly because there was a need. There is a need here. And I just cannot understand that kind of an incredibly bureaucratic, redtape, slow approach to a serious problem. It is a can't-do rather than a can-do approach. And I am disgusted with that attitude. I really am.

Ms. LIVINGSTONE. Sir——

Senator CRANSTON. I seldom get as aggravated as I am over this situation. It is the worst foot dragging that I have seen by the bureaucracy, and bureaucracy is the word to describe it.

Ms. LIVINGSTONE. Believe me, we are very concerned at the VA as well about the length of time it takes us to design and construct our facilities. And that is what prompted the Administrator to contract with Booz-Allen and RTKL to do an entire study of these procedures.

What I am talking about, however, is not our internal mechanisms, but how long it took our contracted A/E to design the current facility. And that was 13 months alone.

Senator CRANSTON. Well, maybe you need a better firm. If they have done that basic work, it does not take as much to change the fundamental plan where much of the work done for the original plan applies to any revisions of the plan.

There is no use arguing about it. But I would like to have a written statement in detail outlining why you cannot do it, explaining all the reasons you cannot, but also explaining how you might do it if you can do that.

Ms. LIVINGSTONE. OK. The——

Senator CRANSTON. Let's not discuss it anymore at this point.

Ms. LIVINGSTONE. Technically it can be done. It is a question of time.

[Subsequently, the Veterans' Administration submitted the following information:]

Senator Cranston indicated that architectual experts have advised him that a downsizing of the Houston project is possible in 3–6 months. We agree that this is possible architecturally, but only if the objective is primarily to reduce beds. The VA's architect-engineer could adjust the current design by removing six nursing unit modules. However, as noted earlier, a major bed reduction of this nature responsibly requires a total reassessment of this VAMC's future mission and affiliation. This approach does not allow time to accomplish these essential activities. Further, significant cost reductions would only result from reducing the number and size of the specialized clinical support spaces. These spaces can be effectively reduced only by proceeding through a comprehensive reassessment of medical programs and space programs, involving full user participation, as previously indicated.

Notwithstanding the above discussion, the VA continues to support the VA/GAO bed model which projects 927 hospital beds, for a total of 1,047 including 120 nursing home care beds, needed for the VAMC Houston. The model that is used by the VA was developed, at the direction of Congress, by a group from the VA and the General Accounting Office. It is a well thought out model that considers not only VA historical experience, but also private sector factors, such as length of stay. It is also responsive to the VA's legislative mandate to care for eligible veterans. Based on the statutory mandate and Congressional acceptance of the model, the VA sizes its facilities utilizing its output. Because of the broad policy implications for the VA's health-care delivery system, any revisions in this model should be publicly presented and debated as a separate issue. The VA strongly supports the Houston replacement project as submitted in the fiscal year 1986 construction budget request.

Senator **Cranston**. Of course it can be done. The question is time and expense. Let's take another look and see if you cannot come up with a more reasonable approach to it.

Dr. **Gronvall**. Sure. We will be happy to revisit the question and supply a detailed response, Mr. Chairman.

Senator **Cranston**. I beg your pardon?

Dr. **Gronvall**. We will be happy to supply a detailed response.

[Subsequently, the Veterans' Administration submitted the following information:]

At the outset it is imperative to understand that the VA considers the responsible way to implement a major scope reduction in any project, such as suggested for Houston, is to require a complete reassessment of both medical program/service planning and construction program planning. We believe that our normal planning process, although time consuming, results in the most efficient and cost effective health-care delivery operations and architectural-engineering solution over the long term life of the building. This approach, therefore, entails far more than simply a "solution to effect an architectural redesign" of the project.

Initially, medical program and service requirements for Houston would be reassessed in terms of the appropriate bed mix for the reduced bed level, the complementary ambulatory care program level, the appropriate extent of ancillary and support services to be provided, and the integration of the affiliation and sharing agreements with the Baylor College of Medicine. The resulting space requirements program is tailored to each and every specific medical program to ensure that only the necessary space is constructed.

Subsequently, construction program planning would reassess the basic conceptual design alternatives to ensure the most efficient and cost-effective solution. The major downsizing suggested for Houston would demand a restudy of the current horizontal building and its associated functional relationships. Restudy of the basic nursing unit layouts (triangular vs. racetrack vs. "H" designs), and complete restudy of materials handling systems also would be required for a smaller Houston hospital.

Based on these needs, replanning and redesign of a major project such as Houston would not vary from our normal process and would take about 25 to 36 months. The timeframe would be nearer the 25-month span depending upon: (1) the extent to which the original medical program and space requirements planning could be reused, and (2) the availability of manpower to provide an all-out effort on this project without compromising the many other projects in the VA construction program.

Major decisions could be expedited by tasking them to a small group, however, this approach ignores the value the VA has found in comprehensive user participation and it would not be a significant time-saving factor in the total redevelopment process. The majority of the decisions are specific to each using service in the hospital. In keeping with our normal practice, coordination would be required with Medical Center management, medical school officials, and all using services to arrive at responsible decisions on all matters pertaining to medical program planning and design. Detailed coordination of the design is also required with Office of Construction technical services to assure compliance with all current standards and codes and to assure the most cost effective design solution.

While time consuming, this participative decisionmaking process ensures the resultant project meets the specific needs of each user, results in greater user satisfaction, assures the optimal design, and avoids potential problems later on in construction and in the long term operation of the facility.

Senator CRANSTON. Would you please relay my concerns to Mr. Walters?

Ms. LIVINGSTONE. Certainly will, sir.

Dr. GRONVALL. Certainly will.

Senator CRANSTON. Dr. Gronvall, in testimony submitted at yesterday's hearing Senator Mathias noted his understanding that if the VA were given the go-ahead to construct the replacement hospital in Baltimore tomorrow the existing drawings and design could be updated in 4 to 6 months and actual construction could begin in 1985.

Exactly when were the working drawings on the Baltimore project completed?

Ms. LIVINGSTONE. About 4 years ago, sir.

Senator CRANSTON. I realize this is a pretty big if, but if the VA were to decide to proceed with the replacement facility in downtown Baltimore and if the necessary resources were to be made available for that purpose tomorrow, would it be possible to revise and update the plans for that project within the timeframe noted by Senator Mathias and have construction begin on the project within 1985?

Ms. LIVINGSTONE. Within the current calendar year? At this point I do not know what the impact of the current Department of Medicine and Surgery study is on bed level there. The current design is for 400 beds. If there are significant changes in that we would have to go back and work with our architectural firm and see what kind of timeframes we are talking about. I assume that it may be possible to do.

Senator CRANSTON. Would that be another 24 to 36 months with *x* millions of dollars?

Ms. LIVINGSTONE. I really do not know what the degree of change might be suggested in the DM&S study.

Senator CRANSTON. Well, could you consider in what timeframe—and make it minimal rather than maximal, if you can—you might be able to accomplish that in and report back to us?

Dr. GRONVALL. Yes. I should, I should comment as an addition to that that at the request of the Congress we have restudied the entire Baltimore area and the hospital needs in Baltimore. We have a report, which is now in final draft stage, which is due back to the Congress on the first of April, making a recommendation out of a total reassessment of the needs in Baltimore. And we will be happy to——

Senator CRANSTON. When can we expect to receive that report?

Dr. GRONVALL. It is due April 1. It is in final draft stage, has not yet been reviewed or endorsed by the Administrator, but we expect that shortly. And I expect we will be close to the April 1 deadline.

Senator CRANSTON. Could we get it in April, by April 15, say?

Dr. GRONVALL. I believe so, yes.

Senator CRANSTON. I would like to go on to one other matter that I consider very, very weird. As you may be aware, I wrote to the Administrator on November 16, 1984, and again on January 3, 1985, regarding the truly awful parking situation that exists at the VA Medical Center in San Francisco and how that situation relates to the construction of a 120-bed nursing home care unit there. In both letters I urged that the VA take the steps necessary to permit it to proceed to the construction of all four tiers of the planned parking structure as an add alternative.

On January 30, I received a response from Administrator Walters advising me that the VA has plans to construct the nursing home care unit with the parking structure but will not do so until the House Appropriations Subcommittee on HUD and Independent Agencies has completed its negotiations with the National Park Service with respect to the leasing of land at the adjacent Golden Gate National Recreation Area.

I have also received a copy of the January 28 letter from the chairman of that subcommittee, Representative Edward Boland, to Administrator Walters laying out a proposal to transfer from the VA's construction account to the medical care account the $4 million that would be available if the two-level parking garage were not built and, in lieu thereof, for the VA to lease 3 acres of land of the Golden Gate National Recreation Area for parking.

Mr. Boland further notes that if at the end of a 3-year period the budget situation has improved and the National Park Service does not want to extend the lease "favorable consideration will be given to funding a parking garage" at the San Francisco VAMC.

Quite frankly, this is a very frustrating situation. I have been trying for well over 4 years to find some acceptable solution to this problem. And it seems to me we are no closer now than we were 4 years ago.

I just received a copy of a March 19 letter from the Director of the Golden Gate National Recreation Area, Jack Davis, to the Director of the San Francisco VAMC, Dr. Larry Foy, dealing with the issue of parking on the Golden Gate property. In this letter, Mr. Davis expresses great concern regarding the environmental impact statement for the construction project, which was based on the undertaking of the parking garage prior to or at the time construction of the nursing home was initiated, and the fact that the VA is not in compliance with the conditions of the current special use permit for VA parking. He requests a reply within a month.

Dr. Gronvall, staff has given you a copy of this letter, which is quite brief. Have you had an opportunity to read it?

Dr. GRONVALL. Yes. We received it this morning and have reviewed it.

Senator CRANSTON. Do you know why the VA has not taken steps to comply with the conditions of the current special use permit for parking?

Dr. GRONVALL. Senator Cranston, the matter of San Francisco parking I agree has been a long and wearisome event. Let me turn to Mr. Falco, who has been very intensely involved through all of those steps, including having this morning reviewed the most current letter.

Mr. FALCO. Senator, we are trying to accomplish actions that we really do not have as much control over as we would like to. As you know, previous construction budgets allocated moneys to build two levels of parking in San Francisco with the garage.

Senator CRANSTON. What I was really asking is why have you not complied with the conditions?

Mr. Falco. The House Appropriations Committee has indicated in deliberations with us that they were going to move forward with a proposal to delete the existing two levels of parking.

Senator Cranston. I do not know what that has to do with this. You have an agreement with GGNA to comply with their conditions.

Mr. Falco. Well, as part of our deliberations with the Appropriations Committee, it has been indicated to us that we should not move forward to pave the parkland until the resolution of these other matters is complete. We have been taking their suggestion as directive in nature.

Ms. Livingstone. Senator, if I could add to that——

Senator Cranston. Well, isn't there an agreement between two Federal agencies in effect that you will take certain steps and you are not taking them?

Mr. Falco. That agreement seems to have been achieved But in spite of that agreement, the Appropriations Committee has indicated we should not move forward to complete the parking lot on the land until the other issues are settled.

Senator Cranston. You have no plans for complying?

Ms. Livingstone. Yes, sir. We do have plans for compliance. And we would like to move forward quickly on it. The House Appropriations Committee, however, has taken the position they do not want the VA moving on an interim solution until a permanent solution has been evolved. So at this point we are a little handicapped in moving forward.

Senator Cranston. Well, what are your intentions? What do you intend to do?

Ms. Livingstone. I share your concern about the frustration here. At the current time we are trying to negotiate with Interior to achieve 3 acres of land that we can use at least on a temporary basis for 5 years at the direction of the House Appropriations Committee.

The difficulty here, sir, is it will require a review of the VA's environmental process as well as probably an EIS statement from Park Service.

Senator Cranston. According to Mr. Davis, the current lease expires on April 30, 1986. What is the VA's intention if the Park Service will not renew the current lease?

Ms. Livingstone. We would come forward to Congress, particularly the House Appropriations Committee, and ask them if they would allow us to move forward with our original intention to build a parking structure at San Francisco.

Senator Cranston. Then you lose 500 parking spaces at that point, right?

Ms. Livingstone. With the construction? I think 82 spaces or something to that effect are lost to the nursing home construction out there. There is a current existing deficit. The parking situation is quite severe in San Francisco.

Senator Cranston. If you do not re-lease and then you seek to proceed with the building of the structure you are out of many parking spaces for a significant period of time, as I understand it?

Ms. Livingstone. That is correct, sir.

Senator Cranston. What would you do during that time?

Ms. LIVINGSTONE. I think it would be very difficult to proceed with the nursing home based on the fact that our environmental process supported the construction of that facility addressing public concerns about parking impact.

Senator CRANSTON. Yes, well that is the point of my question.

[Mr. Davis states as follows:]

It must be understood that use of the GGNRA property for VAMC parking may only be viewed as temporary to stay within the legislative mandate under which we operate. There must be a VA commitment to construct the garage before or at the time the nursing care facility is constructed.

In other words, Mr. Davis is making clear that even if the Park Service is willing to renew the current lease beyond April 1986, it will not do so unless the parking garage is being constructed during the period of the lease renewal.

Isn't it clear from this that the Park Service has rejected any notion of continuing the current parking arrangement, except on the conditions that the VA shows by proceeding with the four-level garage that that arrangement is strictly time limited and that the parkland will revert back to GGNRA as soon as the garage is completed?

Dr. GRONVALL. Senator Cranston, that, of course, is a position that we have only this morning seen, as you know. It would appear to be in conflict with the position and strategy that the House Appropriations Committee had developed. And I think although we have reviewed the letter, we cannot really speak for what the Appropriations Committee response to that new position would be.

Senator CRANSTON. I do not think it is a matter of your speaking for Mr. Boland's viewpoint, it is a matter of your speaking to him and explaining the situation to him. Have you done that?

Dr. GRONVALL. No, because——

Senator CRANSTON. Do you intend to do that?

Dr. GRONVALL. No. Because this letter we were just seeing——

Senator CRANSTON. Do you intend to do it?

Dr. GRONVALL. We only were handed a copy of it this morning during the hearing.

Senator CRANSTON. What will you now do about Mr. Boland's position?

Dr. GRONVALL. I think our intent will be after the hearing to again sit down outside of this room more calmly, review the letter, and review the situation with the House Appropriations Committee to see whether a new or different strategy should be adopted.

Senator CRANSTON. Well, I urge that you go with the approach of the add-on, which is the only way to resolve the problem, apparently.

Dr. GRONVALL. Yes; I think we are as anxious as you to see a workable and permanent solution to the issues so that the nursing home can be built and meet the need which is clearly defined and exists.

Senator CRANSTON. Well, the 3-year lease is no permanent solution.

Dr. GRONVALL. Correct.

Senator CRANSTON. It seems to me the add-on is the only solution that can work. And I would like to have you report back to us as soon as possible your judgment of that matter.

Dr. **Gronvall**. We will be pleased to do so.

Senator **Cranston**. Thank you very much.

Dr. **Gronvall**. Thank you.

[Subsequently, the Veterans' Administration submitted the following information:]

As directed by the Chairman, House Subcommittee on Public Lands and National Parks and the Chairman, House Subcommittee on HUD-Independent Agencies, Committee on Appropriations, the Veterans' Administration (VA) is currently meeting with National Park Service (NPS) officials in Washington, DC to ascertain their final position on the use (temporary or long-term) of the Golden Gate National Recreation Area (GGNRA) lands. Subsequently, we will be writing to your committee concerning the NPS's position, and, based on that position, the VA's recommendation to resolve the parking problem at the medical center. We hope to achieve our resolution of this matter with the NPS in the next few weeks and be back to the committee in the near future.

Chairman **Murkowski**. Thank you, Senator Cranston.

Senator **Cranston**. Frank, I ask unanimous consent that the letters I referred to appear in the record.

Chairman **Murkowski**. Without objection, they will appear in the record.

[The letters referred to above follow:]

ALAN K. SIMPSON, WY, CHAIRMAN
STROM THURMOND, SC
ROBERT T. STAFFORD, VT
FRANK H. MURKOWSKI, AK
ARLEN SPECTER, PA
JEREMIAH DENTON, AL
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GEORGE J. MITCHELL, ME
ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

November 16, 1984

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

As you know, I have for some time been pursuing, and trying to help resolve, the issues surrounding the construction of a 120-bed nursing home care unit and parking structure at the San Francisco VA Medical Center.

In your August 31, 1984, letter (a copy of which you were kind enough to send me), transmitting to the Chairman of the Appropriations Committee a listing of major construction projects for fiscal year 1985, you stated that the Administration's request for $3 million for the additional 2 tiers of the parking structure (for a total of 4 tiers) was being withdrawn until after a final decision was made on the idea of a transfer of a parcel of land at the Golden Gate National Recreation Area (GGNRA) from the Department of the Interior to the VA. You further noted, "Should the land transfer not be effected, it will be necessary for the Veterans Administration to recommend alternative construction approaches to resolve the parking situation."

As you will recall, on September 11, the Subcommittee on Public Lands and National Parks of the House Committee on Interior and Insular Affairs, chaired by Congressman John Seiberling, held a hearing on the land transfer issue. None of the witnesses who appeared at the hearing testified in support of the land transfer. Representative Sala Burton joined me and witnesses from the Interior Department, the National Parks and Conservation Association, and the Sierra Club in opposing the transfer.

Subsequently, by letter of September 26, 1984, Congressman Seiberling advised Congressman Edward Boland, Chairman of the House Subcommittee on HUD-Independent Agencies Appropriations, that he was recommending only a five-year lease of up to three acres of GGNRA land for VA parking.

Inasmuch as it appears certain that the land transfer will not be accomplished, I would appreciate hearing from you as to what actions you plan to take with respect to alternative construction approaches to resolve the parking dilemma at the San Francisco VAMC. In this connection, I should stress that I continue to believe that there is a strong possibility that the entire 4-tier structure -- if constructed all at one time -- can be completed for considerably less than the $7 million projected by the VA. Thus, I strongly urge that the VA pursue aggressively the so-called "add-alternative" approach.

Finally, Harry, I understand that the San Francisco VAMC Director, Dr. Larry Foye, believes that, in light of the fact that the unified community support for the construction of the NHCU was premised on the construction at the same time of a 4-tier structure, the construction of the NHCU coupled with just a 2-tiered parking structure would not be an acceptable result and that, if that were the only alternative, he would urge abandonment of the NHCU construction project at the San Francisco VAMC. That would be a most unfortunate result, in terms of both the needs of disabled veterans and their families for nursing home care in the Bay area and the plans of the University of California at San Francisco to make the NHCU the centerpiece of a major commitment by that medical school to geriatrics and gerontology.

I look forward to hearing from you on this very important matter.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

cc: Dr. John W. Ditzler
William Sullivan

ALAN K. SIMPSON, WYO., CHAIRMAN
STROM THURMOND, S.C.
ROBERT T. STAFFORD, VT.
FRANK H. MURKOWSKI, ALASKA
ARLEN SPECTER, PA.
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ALAN CRANSTON, CALIF.
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SPARK M. MATSUNAGA, HAWAII
DENNIS DE CONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

January 3, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

As you'll recall, I wrote you on November 16, 1984, regarding the issues surrounding the construction of a 120-bed nursing home care unit and parking structure at the San Francisco VA Medical Center. Enclosed is a copy of my letter, in which I urged the VA to pursue the so-called "add-alternative" approach to construct a 4-tier parking structure.

To date, I have not yet received a response to my inquiry as to what actions the VA plans to take with respect to alternative construction approaches to resolve the parking dilemma at the San Francisco VAMC. I would, therefore, appreciate hearing from you at your earliest opportunity on this vital matter.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

United States Department of the Interior
NATIONAL PARK SERVICE
GOLDEN GATE NATIONAL RECREATION AREA
FORT MASON, SAN FRANCISCO, CALIFORNIA 94123

IN REPLY REFER TO:

rec'd 3/25

L30 (WR-GOGA)

March 19, 1985

Laurance V. Foye, Jr., M.D.
Director
Veterans Administration Medical Center
4150 Clement Street
San Francisco, California 94121

Dear Dr. Foye:

This letter is a follow-up to my communication of January 25, 1985 dealing with the issue of VAMC parking on property of the Golden Gate National Recreation Area.

Chairman Edward P. Boland, Subcommittee on HUD-Independent Agencies, Committee on Appropriations, in his letter of January 28, 1985 to Administrator Walters, makes it clear that his Subcommittee will not review funding for a VA parking garage for three years and only then if the national economy has improved. This is of great concern as the VA environmental impact statement decision assured, the California Coastal Commission required and the San Francisco Board of Supervisors resolved that the parking garage be undertaken before or at the time the nursing care unit was constructed.

Furthermore, the VA is not in compliance with the conditions of the current special use permit for parking. The permit requires the VA to improve the temporary parking, road access and to restore a specific portion of GGNRA property so that it can be managed for park purposes. Nothing along these lines has been accomplished. I must ask the question; what is the intention of the Veterans Administration with respect to carrying out the conditions of the permit No. 4-8410-0696 valid for the period of May 1, 1984 until April 30, 1986? Your answer is respectfully requested within a month. We must structure appropriate action as we face the uncertain future of VA funding for major development.

The current condition of the temporary parking area and parking within the tree zone are intolerable. The situation does not speak well of our collective management of this situation. The fact that the funding rules keep changing can no longer be an excuse for not dealing with this matter in a forthright manner.

It must be understood that use of GGNRA property for VMAC parking may only be viewed as temporary to stay within the legislative mandate under which we operate. There must be a VA commitment to construct the garage before or at the time the nursing care facility is constructed. Our solution must be sensitive to the parking impacts on the surrounding residential area.

Your support as we work through this difficult issue is appreciated and I look forward to your early response.

Sincerely,

John H. Davis
General Superintendent

cc: Regional Director, Western Region w/c of Mr. Boland's letters

bcc: Frank Boerger w/c Mr. Boland's letters
Amy Meyer w/c Mr. Boland's letters
John Jacobs w/c Mr. Boland's letters
Lowell Johnson
Shirwin Smith
Steve Gazzano

JAMIE L. WHITTEN MISS. CHAIRMAN
[illegible]

[illegible]
CLERK AND STAFF DIRECTOR
[illegible]
TELEPHONE
(202) 225-2771

Congreſs of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

January 28, 1985

Honorable John F. Seiberling
Chairman
Subcommittee on Public Lands and
National Parks
Committee on Interior and Insular Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear John:

Enclosed is a letter I sent to the Administrator of Veterans Affairs regarding a proposed construction project at the San Francisco VA Medical Center. In view of the large budget deficits and the urgent medical needs of the VA, the proposal appears very responsible and reasonable. It saves construction funds now and increases medical care funding for important activities such as post-traumatic stress disorder -- a major concern to Vietnam era veterans. A portion of the funds could also be used for specific needs at the San Francisco VA Medical Center.

As I indicated in the letter to Administrator Walters, if, at the end of three years, the budget situation has improved and the National Park Service does not want to extend the lease, favorable consideration will be given to funding a parking garage. According to the VA, only three trees would be removed to provide approximately 100 parking spaces more than would be provided by a four-level parking garage structure. I would also point out that current National Park Service activities and structures would not be affected.

I want to thank you and the subcommittee for your help and consideration.

Sincerely,

Edward P. Boland

Edward P. Boland
Chairman
Subcommittee on HUD-Independent
Agencies

Enclosure

EST COPY AVAILABLE

Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

January 28, 1985

Honorable Harry N. Walters
Administrator
Veterans Administration
Washington, D. C. 20420

Dear Mr. Administrator:

In fiscal year 1984, $14,700,000 was appropriated for a 120-bed nursing home care unit and two-level parking garage project at the San Francisco VA Medical Center. Subsequently, there has been brought to our attention alternate proposals which would negate the need for building the parking garage.

As I understand it, Mr. Seiberling, Chairman of the Subcommittee on Public Lands and National Parks of the Committee on Interior and Insular Affairs, has asked the National Park Service to enter into a five-year lease for up to three acres of land in the East Fort Miley area for use by the VA as a parking lot. This should allow the VA ample space to park approximately 450 cars without building a parking garage -- and without disturbing any existing Park Service administrative buildings or functions. Perhaps more importantly, it would also save approximately $4,000,000 of the $14,700,000 appropriated in fiscal year 1984. It would also negate the need in a subsequent fiscal year for appropriation of approximately $3,000,000 for the third and fourth levels of the parking garage.

At the earliest possible opportunity, I would propose transferring the savings generated from not building the two-level parking garage (approximately $4,000,000) from the "Construction, major projects" to the "Medical care" appropriation. In light of possible reductions in funding for veterans medical programs and the increasing number of elderly veterans, I believe transferring these funds represents the highest priority use of the money.

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The Veterans Administration should utilize the three acres in the Golden Gate National Recreation Area for the purposes of parking and proceed with the 120-bed nursing home care unit project. If, at the end of three years, the budget situation has improved, and the National Park Service does not want to extend the lease, favorable consideration will be given to funding a parking garage.

Based on discussions between the Chief Medical Director, Dr. Ditzler, and the Committee staff, I know that an environmental impact assessment may be required to proceed with this option. I have the highest confidence, however, that the VA will persuade any concerned parties that this option satisfies any environmental issue.

Thank you for your help and consideration.

Sincerely,

Edward P. Boland
Chairman
Subcommittee on HUD-Independent Agencies

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

FEB 1

JAN 30 1985

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear ~~Senator Cranston~~: Alan

Thank you for your letter of November 16, 1984 and your follow-up letter of January 3, 1985, expressing interest and concern regarding an effective solution to resolving the construction issues relating to the planned "120-bed Nursing Home Care Unit and Parking Structure" at the Veterans Administration Medical Center, San Francisco, California.

As you know, the VA has been working closely with the House Appropriations Committee staff to resolve parking deficiencies at VAMC San Francisco. The Committee has recommended a five-year lease for three acres in the Golden Gate National Recreation Area to provide a solution to the parking deficiencies. However, negotiations with National Park Service over the past six months for a five-year lease on sufficient land to meet the VA's parking requirements have not been completed. We feel this issue is nearing a resolution, and we would like to defer a substantive reply to your concerns for several weeks.

In closing, let me reassure you, we have plans to construct the nursing home care unit with the parking structure, and we will do so when the House Committee has completed its negotiations.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

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Senator CRANSTON. You were not present briefly when I was expressing my concerns about the Houston situation that the two Senators were expressing. I just cannot understand how it can take so long to do a downsizing. And I have asked them rather vigorously for an explanation once again of why it has to take that long and what could be done to speed that up.

I think the two Senators have a very valid concern. But there are reasons to wonder about the validity of proceeding with the originally planned size institution. And downsizing should not take that long, it should not cost us that much. And I would like to have a better explanation than I have heard of why something cannot be done.

Chairman MURKOWSKI. Have the witnesses indicated that they would be submitting that for the record?

Senator CRANSTON. They have indicated they will submit it for the record, but they gave me no encouragement on doing anything other than taking an incredible length of time to do a job that I cannot understand requiring that time.

I recall when the Pentagon was built, which is one of the largest buildings and a rather unique design, and that was done like a shot at a time when it was needed.

This is a need that is not that great in terms of our national security and survival. We were in the middle of World War II then. But nonetheless, this is for veterans of war and we should be able to meet their needs expeditiously and not with an incredibly long bureaucratic, time consuming, incomprehensible delay.

Chairman MURKOWSKI. Senator, I am not familiar with the project in any great detail. I assume because of its rather unique design that one of the quads might be removed. Is that a conceivable alternative to maintaining the same plan and just putting in less beds?

Dr. GRONVALL. I believe not, in that——

Chairman MURKOWSKI. Would you indicate why not?

Dr. GRONVALL. In our further response? Or would you like a comment now?

Chairman MURKOWSKI. I would like to hear your comments now.

Dr. GRONVALL. Yes; when a hospital is planned there needs to be developed a plan for how many beds of what sort are in the hospital—medicine, surgery, special care units, spinal cord injury, et cetera, et cetera. Plans are then developed for the supporting units of laboratory, surgery, x rays, other support services that have to be sized on that basis.

When a conceptual design is developed for a project it takes into account the spaces needed for each of those various activities as well as the functional interrelationship of the various services to the support activity.

Chairman MURKOWSKI. At 100 percent occupancy?

Dr. GRONVALL. No; our projections are based on an occupancy projection that is clearly less than 100. Hospitals do not operate at 100 percent.

Chairman MURKOWSKI. What is it based on?

Dr. GRONVALL. We use 75-percent occupancy as a minimum standard throughout our system.

The present Houston hospital is in the high 80's.

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When then a major change in the size of a hospital is to be accomplished it requires revisiting those decisions. And it is not possible to just take off two floors or take off one end of the building because one must restructure and reconfigure the bed services and the support elements. And that requires some planning time by medical professionals. It also then requires the architects and engineers. And that is the major source of the time, to redevelop a concept for the project using the space assigned to the resized functions and insure that the hospital is going to work as an operating entity.

And I think it is a complex matter that does require some care. I think our response would be that shortchanging the review in the interest of saving a few months in the construction process at that point would be a poor economy if you then have a hospital operation for the next 50 years in which the function is disadvantaged by not having taken some time to think through how the hospital is actually going to operate.

Chairman MURKOWSKI. It was my understanding that the planning time involved in changing this would be substantial.

Ms. LIVINGSTONE. Planning and redesign. That is a guesstimate.

Chairman MURKOWSKI. Yet the private sector does it in 3 or 4 months simply because time is money. What is the magic? You have already eliminated two floors from the original facility. The facility was originally designed to operate 1,400 beds, and you are now down to 1,047. How long did that take to do?

Ms. LIVINGSTONE. That was done during the conceptual stage of the project, sir. And during preliminary design you get a far more detailed architectural layout. What we are talking about here are major—such as mechanical, electrical, plumbing, et cetera—systems being shown on the design would have to be changed.

Chairman MURKOWSKI. I believe you said it takes 2 years?

Dr. GRONVALL. Three years.

Chairman MURKOWSKI. Three years?

Ms. LIVINGSTONE. Well, this is including the VA's reprogramming time in terms of our own downsize decisions.

Chairman MURKOWSKI. Why does it take the VA so much longer than the private sector?

Ms. LIVINGSTONE. I would be curious what the private sector does within that 3-month period, if they are utilizing standard layout plans which are just site adapted or if they are doing redesigns for individualized service deliveries in those hospitals.

Chairman MURKOWSKI. The fact is—they get a hospital built and it is functional and it serves its purposes.

Ms. LIVINGSTONE. Yes, sir.

Chairman MURKOWSKI. And that is what hospitals are designed to do. And if yours takes that extraordinary additional time, my question is why?

Ms. LIVINGSTONE. If we were doing that on a repetitive basis I am sure that there would be tremendous time savings. If we were building hospitals that were fairly standardized in their service layouts, bed sizes, things of that nature, you could reuse designs.

Chairman MURKOWSKI. Is it not appropriate to consider standardization?

Ms. LIVINGSTONE. I think——

Chairman **Murkowski**. For example, an airplane has a fairly standard design. There are three or four different designs, then after that they are all the same.

Dr. **Gronvall**. Yes. I believe, Mr. Chairman, the medical mission of each of our hospitals varies considerably. We have attempted to create and to further the concept of a regional distribution of care in which not every hospital has the same mission, in order to have a more effective district and regional concept. Some hospitals serve a tertiary care mission with highly intense levels of care, including educational support and research activities that relate to patient care. Those hospitals are very complex and do not lend themselves to standardization.

Other hospitals that serve a different mission require their own individualized kind of planning.

Chairman **Murkowski**. That occurs in the private sector, too. Hospitals provide different types of services.

Ms. **Livingstone**. I assumed that is what you might be referencing, sir. And I noticed you have representatives from HCA here. Really what the degree of their architectural time and what type of architectural variations occur on their designs from hospital to hospital would be better addressed by them. I really do not know.

Chairman **Murkowski**. Well, is it fair to say that they probably do not build hospitals like this in the private sector simply because they cannot possibly afford them? In your opinion, could that be a possibility?

Dr. **Gronvall**. I believe that there are a good many hospitals in this country built in the private sector that are larger, more complex and more costly than the proposed Houston Hospital.

Chairman **Murkowski**. We will have an opportunity to ask the private sector a little later.

Senator **Cranston**. I consulted one A&E firm that is reputable and been successful, and they believe that it should be possible to redesign the preliminary plans and get going conceivably in 3 and at most in 6 months. That would fit pretty well within the general timeframe that we have been operating under at this stage.

Ms. **Livingstone**. This is in terms of downsizing from about two——

Senator **Cranston**. Yes.

Ms. **Livingstone** [continuing]. Two or three hundred beds from a——

Senator **Cranston**. Yes.

Ms. **Livingstone**. And the resulting support services differences?

Senator **Cranston**. Yes. After the decisions are made. But you can make the decisions about what you are going to do by getting the people together in one place for 1 week or less.

Ms. **Livingstone**. Bill, do you want to comment on the technical side on that? [Pause.] Apparently not. Senator Cranston, again we share your concerns about the length of time it takes to deliver any type of service the VA needs to deliver. The situation here is we do use contract A/E's. Ours, in this case, took 13 months. I do not know if that is because of the specifications or criteria or it is just that that was the standard critical path method for that particular design. That another A/E can do it in 3 months, you would have to put the two together and let them compare how one functions and the other does not. I just really cannot address that question without more data.

Senator CRANSTON. I think we should be setting those higher standards. I have always considered Harry Walters to be a can-do administrator. I would like to see him stick to that and not become a can't-do on this one.

Ms. LIVINGSTONE. Absolutely.

Senator CRANSTON. Thank you very much.

Dr. GRONVALL. Thank you.

Chairman MURKOWSKI. Thank you, Senator.

Have you had an opportunity to review the Booz-Allen report in its preliminary draft form?

Dr. GRONVALL. Mr. Chairman, I would be happy to comment on that. I do have an opening statement that I would like to make at some time. And I wanted to be certain that you knew that.

In regard to the Booz-Allen study, the report is in, the final report is in a draft stage being reviewed. We expect the final report the second week in April.

Chairman MURKOWSKI. My question was more specific. Have you had an opportunity to review any portion of the draft report?

Dr. GRONVALL. Yes.

Chairman MURKOWSKI. Could you highlight the Booz-Allen recommendations as they refer to this particular area?

Dr. GRONVALL. By this particular area?

Chairman MURKOWSKI. I am interested in learning about the Booz-Allen recommendations pertaining to the VA's construction planning process.

Dr. GRONVALL. I can certainly comment on background material and items I have read in the report. I am troubled about doing that.

Chairman MURKOWSKI. I am concerned with their draft recommendations of issues relating to hospital planning.

Dr. GRONVALL. I do not know what the recommendations on the report are going to be because it is a draft report. And I think draft reports are developed explicitly for the purpose of allowing them to be reviewed by both technical and policy people to insure that the report is factually based and technically sound. That process has not occurred. So I would be describing something which may, in fact, not be a set of recommendations that will be made to Mr. Walters.

Chairman MURKOWSKI. I thought that these were preliminary recommendations. I believe it would be appropriate, since Federal funds paid for the study, that they be available to the members of the committee.

Dr. GRONVALL. I think you are asking now a somewhat technical question. Perhaps Mr. Thomas or other people here could answer it.

My understanding is that at the time the report is actually submitted to Mr. Walters, that is the time that the recommendations then exist as a set of recommendations that are made available and are available. And that has not yet occurred.

Chairman MURKOWSKI. So you have read certain drafts. Have you read any drafts which address the hospital planning process?

Dr. GRONVALL. Yes; in the draft report there are——

Chairman **Murkowski**. You decline to provide to the committee from recollection general information from that draft, is that correct?

Dr. **Gronvall**. My understanding is that the Veterans' Administration was asked to send to the committee a copy of the draft report. And, although I was not a part of the communication, my understanding is that the agency had communicated back to the committee that at this time it was not appropriate to place before the committee the draft report.

Chairman **Murkowski**. I am going to instruct counsel to pursue that. I think it is appropriate, since we have an oversight responsibility to the VA, that we have that information.

At this time, I will not pursue it any further. We have established that for one reason or another it is not available. We will find out why.

Is there a policy within the VA to consider utilization of private facilities or leasing private facilities with an option to buy as an alternative?

Dr. **Gronvall**. Yes.

Chairman **Murkowski**. Has the VA ever done it?

Dr. **Gronvall**. Yes. At the present time, something like 10 or 12 percent of our medical care budget is expended in purchasing care or paying for care delivered by private physicians, private hospitals, private nursing homes through fee basis care, lease agreements. A number, sir.

Chairman **Murkowski**. Has the VA ever purchased a private hospital?

Dr. **Gronvall**. I would have to ask others if the answer to that is yes. Mr. Falco?

Mr. **Falco**. I do not recall ever purchasing a private hospital, but in the early seventies we did acquire a medical center at St. Albans, NY, and did in fact convert that to an extended care facility.

Chairman **Murkowski**. Was that from the private sector?

Mr. **Falco**. No; it was from the military, the Navy.

Chairman **Murkowski**. That was acquisition of a Government hospital. Has the VA ever purchased a private hospital?

Mr. **Falco**. Yes. My recollection is we have never purchased——

Chairman **Murkowski**. Is the VA considering purchasing or leasing any facilities?

Dr. **Gronvall**. Oh, yes, as Senator Denton commented, we are intensively reviewing the Providence Hospital in Mobile to consider whether it would be appropriate for the Veterans' Administration to acquire that hospital.

Chairman **Murkowski**. Is Providence in your plan or not? Is it a hospital you want? Or have you made a decision?

Dr. **Gronvall**. No; that review has not been concluded, so a decision has not been made.

Chairman **Murkowski**. How many others are the VA considering?

Dr. **Gronvall**. I cannot give you a specific number, but during the past year that question has been raised about at least three, four or five other hospitals and we have, we have reviewed first the question of whether there is need for a veterans' hospital in the area. In a number of instances it was clear that there was not an existing need so nothing further was done. There have been other instances where a need existed so a visit has been made to a private facility to assess whether or not the facility would be adequate, et cetera, et cetera.

So that deliberation has gone on in a number of instances.

Chairman Murkowski. Senator Denton has explicitly indicated that there is a need for beds in the Mobile area. I think that is district 10, is that not correct? However, the VA has indicated that there is no need for additional beds in district 10. Senator Denton has indicated that the Panhandle of Florida, for which the VA has determined there is a need for beds, is only 40 miles away. Of course that involves a new hospital. I am wondering if you would, for the benefit of the record, try and reflect on this differential. It appears that the 40 miles are the determining factor. I have yet to identify which hospital you have on your list of medical centers which is going to meet this need. Can you tell me which facility will meet this need?

Dr. Gronvall. Mr. Chairman, let me back up a little bit to describe a series of events that may be helpful.

Chairman Murkowski. First, identify for me which hospital you have recommended in Florida, specifically?

Dr. Gronvall. Well, there have been four hospitals proposed.

Chairman Murkowski. I have Gainesville and Palm Beach.

Dr. Gronvall. There was an earlier planning study that set out a 30-year projection in which there were identified needs that would justify, in the judgment of the report, four hospitals in Florida: one in Palm Beach, which is before you——

Chairman Murkowski. That is due to be designed in 1987.

Dr. Gronvall. Yes. A second in Brevard County; a third in Lee County area; and the fourth in the Panhandle of Florida. And those were all developed through an intensive planning effort done really at the request of the Congress. And those planning reports have been made available to the committees. And so, the background of the development of those recommendations has been clearly placed before the Congress.

Chairman Murkowski. Well, I do not have the Panhandle on our list.

Is it a policy within the VA to plan facilities within districts?

Dr. Gronvall. Yes.

Chairman Murkowski. You do not go across districts.

So here we are talking about one in district 10 and one in district 12?

Dr. Gronvall. No. The answer to the second part of your question is no. The district planning utilizes the medical district as the basic planning unit. There are 28 districts in the country. A part of district planning is to also consider interdistrict movement of patients of the ways in which adjacent districts serve the needs of veterans who, because of the place they live, may cross district boundaries.

The district boundary has no magic in it. It is not intended to be, nor does it function, as a barrier to treatment of veterans across district lines. The districts were developed only to be a functional unit of planning geography.

Chairman **Murkowski**. The VA states that there is no need for additional beds in district 10. Is that correct or incorrect?

Dr. **Gronvall**. We have not said that, to my knowledge.

Chairman **Murkowski**. We will request Senator Denton's staff to clarify that. Senator Denton contended that "the VA says there is no need for additional beds in district 10."

What are your plans for Alabama for beds? You say there is a need for beds. Is this correct or is that not correct?

Mr. **Falco**. I am really not sure about the question.

Chairman **Murkowski**. The VA says there is no need for additional beds. You just stated that to your knowledge, that VA has not said there was no need for additional beds in district 10. My question is then what plans do you have for district 10?

Mr. **Falco**. Maybe we need to backtrack. I think I understand what the difference is as far as understanding.

We made a study of Florida which included the Panhandle of Florida and the areas that the districts in Florida serve. Out of that 30-year study there was indicated a need for four new hospitals in the State of Florida. The question that has arisen is could that need be met by buying the Providence Hospital in Mobile to substitute for the need that we described to be beds in the Florida Panhandle. That deliberation is taking place right now in the VA.

I think what Senator Denton was saying is that the local people have concluded that the need to put beds in that particular location is not necessary. That final deliberation has not been made at the Central Office level, but the local people have concluded that putting hospital beds in Mobile does not, in their view, meet the need.

You say there is a 45-mile difference.

Chairman **Murkowski**. Forty.

Mr. **Falco**. Well, evidently, the debate will need to take place as to whether or not the district's present view and the view of the other districts about where those beds should be located to best meet the needs of veterans.

Chairman **Murkowski**. Well, you were down in the area, observed the Mobile hospital.

Mr. **Falco**. Yes.

Chairman **Murkowski**. How do you evaluate the situation? Is it appropriate to (a) build a new hospital in Florida or, (b) utilize the Mobile hospital?

Mr. **Falco**. I am a construction person. I have looked at that hospital in Mobile and from a construction point of view it is a very, very adequate facility. With regard to Senator Denton, I would not have a problem with agreeing with his description of the hospital.

The basic recommendation that we made as construction people indicated that if the program people felt that the need for hospital beds was in Mobile, one could move along the lines of meeting that need. The program people are making that deliberation.

Chairman **Murkowski**. I really do not care for the bureaucratic banter here. The question is we are talking either district 10 or we are talking Mobile or we are talking Florida. And to beat around the bush with the generalization that the planners do this and the people do this, you know, heaven's sakes, we are either going to consider a policy or we are not. Now, I am asking the VA, and the

VA responded by saying, yes, you follow the policy of considering lease or considering purchase. I have asked how many you have purchased. The answer is zero.

So you have yet to start the process.

Now, my next question is on lease facilities. Are you leasing hospitals?

Dr. Gronvall. Yes.

Chairman Murkowski. In the private sector?

Dr. Gronvall. Yes.

Chairman Murkowski. How many have you leased?

Dr. Gronvall. All right. I am unaware of leasing an entire hospital. We have a number of lease agreements in which a certain number of veterans are cared for in a private hospital across the country.

Chairman Murkowski. So you have not leased any hospitals.

Dr. Gronvall. We have not leased any.

Chairman Murkowski. Have you leased any nursing homes?

Dr. Gronvall. I am not aware that we are leasing an entire nursing home. We have many lease agreements for service delivery.

Chairman Murkowski. The VA has acknowledged that the law allows them to consider purchasing or leasing medical facilities, however, the VA has yet to implement this policy.

Dr. Gronvall. Yes.

Ms. Livingstone. Mr. Chairman, we do lease very significantly in the outpatient clinic area. We have about 31, 32 leases in that area where they are straight leases for usually a 20-year period. And also GSA administers about another 20 or 30 leases for us. They are primarily regional office facilities. So leasing is, on the medical care side, primarily in the outpatient field.

Dr. Gronvall. I think an additional comment might be helpful that in this country it is only within about the past 4 or 5 years that there have been some fundamental changes in health care which have resulted in a significant number of hospitals in the private sector who have declining occupancy and have been suggested as available for sale or lease by the Federal Government. So the environment has changed.

Chairman Murkowski. While the record is open, please provide for the committee a list of facilities that have been brought to your attention as available for sale, or lease, or lease with an option to buy.

Dr. Gronvall. Yes.

Chairman Murkowski. And when I say "facilities" I am talking about hospital facilities and nursing homes. We would like to see what has been proposed in what areas. We would, appreciate any recommendations you would care to make as well.

Dr. Gronvall. Yes.

Chairman Murkowski.We need a little closer examination from the standpoint of where we are going and how we are going to get there. The name of the game is the maximum quality of health care. I would assume that you, sir, would agree that there is no indication that health care cannot be found in a private facility that might be available for as much as one-quarter the cost, which is very appealing. And I recognize this may be a departure, but you know, it is up to us to work together to determine whether the departure is in the best interests of service to our Nation's veterans.

Dr. **Gronvall**. Absolutely. We would be pleased to.

[Subsequently, the Veterans' Administration submitted the following information:]

There are a number of instances when a community hospital has been offered to the VA for purchase or as an outright gift for renovation as a VA owned and operated facility. Before the VA will seriously consider such an offer or will conduct an inspection of such a facility for possible VA use, the agency makes a determination of whether a need exists for expanded VA health-care capacity in the geographic area under consideration. This determination is made through the Medical District Initiated Program Planning (MEDIPP) process. Frequently, the MEDIPP analysis will show there are sufficient exisiting VA facilities in the locale or the projections of the VA potential patient population are not sufficient to justify purchase of the offered community facility.

The following is a list of facilities that have been brought to the attention of the Veterans' Administration as available for sale, where further investigation has seemed warranted. No facilities have been offered for lease or lease with option to buy, except as a part of normal leasing activities, i.e., warehouse space, day treatment centers, outreach clinics, satellite clinics, etc.

Facility	Location	Reviewed
Flowers Hospital	Dothan, AL	March 1984.
Providence Hospital	Mobile, AL	March 1984.
Mental Health Center	Galesburg, IL	July 1984.
West Virginia Industrial School for Boys	Pruntytown, WV	August 1984.
Maryland General Hospital	Baltimore, MD	July 1982.
Nuestra Senora de Los Angeles Hospital	Rio Piedras, PR	February 1983.

The following organizations have approached the VA and offered to build, build and lease, or build and operate Nursing Home Care Units, without specifying a specific location:

Facility	Designation	Reviewed
National Health Care Affiliates	Building and operating	October 1983.
California Association of Health Facilities	Building and operating	February 1984.
Health Group Care Centers, Inc.	Building only	March 1984.
American Health Care Association	Build/lease to VA	Ongoing.

Chairman **Murkowski**. I would appreciate you going into your statement in the degree that you care to within the time restraints that we have. I do apologize for the manner in which we got started, but those things do occur. I want to give you the opportunity to proceed with what statement you feel you want to make.

I would request that you give us an overview of your remarks rather than their introduction in their entirety.

Dr. **Gronvall**. Thank you.

Chairman **Murkowski**. They will be introduced into the record as if read.

TESTIMONY OF DR. JOHN A. GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY RICHARD P. FALCO, ACTING DIRECTOR, FACILITY ENGINEERING, PLANNING AND CONSTRUCTION OFFICE; AND SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR OF LOGISTICS

Dr. GRONVALL. Yes; thank you. We did submit an opening statement, which I appreciate being incorporated in the record.

I thought what I would do really is summarize from that in a brief outline fashion the process that we use for planning which then results in a proposed set of hospital construction recommendations. Much of the discussion yesterday and again today has revolved on that. Let me summarize it briefly.

Our planning process begins first with program planning done at the district level. Program planning is initiated with central office guidance which is based on the congressional, various congressional mandates for care.

Each of the 28 districts develops its own set of medical programs, plans, and projections. Those ultimately are reviewed and finally approved in the VA central office. Once that program plan is complete, each facility in the district is asked to develop its own 5-year projection of construction or facility needs. Those needs fall really into general categories: One, the need to maintain and upgrade the facility and correct deficiencies; and the other is construction needed to meet program mandates.

Out of each of these individual facility plans an aggregated 5-year construction needs assessment is completed. That is supplied to the Congress each year. That 5-year needs assessment is not a budget request, it is a description of needs throughout the entire system.

We utilize then the advance planning fund as a process for insuring that each individual project is developed to the point where we have firm estimates of the project's scope, its cost, and the time for completion. I think the critical part of our planning is a bed-sizing model, originally developed in response to a request from the Congress.

Our bed-sizing model was developed in collaboration with an endorsement by both OMB and the General Accounting Office. So we believe that the bed-sizing model is a sound projection of congressional mandate for care translated to facility needs.

Each project that is developed through the advance planning fund is then prioritized to create a single national list of projects. Those of highest priority are then translated into a budget request. Each year the projection for construction is submitted to agency review to insure that it matches the priorities, meets priorities for operational fund requests as well as construction requests. It then goes through agency and executive branch review and is presented to the Congress as a part of the President's budget request for construction.

So, I appreciate the chance to briefly summarize what we believe is an orderly and coherent planning process.

The last thing I would just do is point to several new initiatives that are underway that we think will further improve the whole process. First, we are doing a capital facilities study.

You commented yesterday on the need to know the physical characteristics of our medical facilities. Some 132 of our 172 facilities are being intensively reviewed to document the physical characteristics and shortcomings of each of those facilities that can be a basis of further planning.

We have developed a new prioritization methodology. That, again, will be the subject of a report that will be submitted shortly.

We have developed a nursing home prototype which we believe will significantly shorten the planning and construction time for nursing homes.

Chairman **Murkowski**. Excuse me. I am going to have to interrupt. I am going to have to go up and vote in the committee and make a statement.

Dr. **Gronvall**. OK.

Chairman **Murkowski**. I am going to ask that Tony Principi preside.

But prior to doing that I would like to know does your construction procedure eliminate the risk of having a significant number of change orders? Is your architectural engineering and design finite enough so that when you go out to bid you can be assured that there would be a very minor range of discrepancies? Or do you use construction planning techniques that afford an opportunity to have change orders as we move along?

Ms. **Livingstone**. Mr. Chairman, when we go out on the market for bids we go with a full set of completed contract documents, completed design documents. Those are bids for a firm fixed price basis that comes in and we award to the low bidder. When we go into that process, we go, obviously, not with any anticipation that there will be necessary or required any change orders. However, depending on the projects, various levels of change orders can come in.

Chairman **Murkowski**. I would like you to provide for the committee a list of litigation on your last 10 projects that involved disputes between the contractor, change orders, architect and so forth and the results of the litigation.

Ms. **Livingstone**. The last 10 completed projects?

Chairman **Murkowski**. Yes; that would be sufficient. In the order of their completion.

Ms. **Livingstone**. We will provide that for the record.

[Subsequently, the Veterans' Administration submitted the following information:]

The following is a list of the 10 most recently activated VA replacement facilities and their associated litigation. Hospitals are activated when the complete facility is made available to the operations department and personnel and patients may move in. Thus, a facility may not necessarily have been completed. For present purposes, litigation is defined as any appeal from a Contracting Officer's decision which has been docketed before the VA Board of Contract Appeals.

RECENTLY ACTIVATED VA REPLACEMENT HOSPITAL FACILITIES

[Dollars in thousands]

VA facility	Number of beds	TEC	Initial fiscal year funding	Activation date	Cost per bed
Lexington, KY	378	15,932	1966	June 1973	$42,000
San Antonio, TX	773	37,088	1966	October 1973	48,000
White River Junction, VT	205	7,753	1968	June 1974	38,000
San Francisco, CA	436	16,778	1969	May 1976	38,000
Los Angeles, CA	832	87,029	1973	March 1977	105,000
Loma Linda, CA	500	64,900	1972	December 1977	130,000
Columbia, SC	400	26,377	1972	June 1979	66,000
Augusta, GA	420	43,200	1971	August 1980	103,000
Bronx, NY	702	115,687	1973	January 1981	165,000
Little Rock, AR	1,305	142,450	1973	August 1984	109,000

Note.—The costs have not been inflated to current dollars but are shown as actual dollars at the time of completion.

RECENTLY ACTIVATED VA REPLACEMENT HOSPITAL FACILITIES—LITIGATION

VA facility	Docket No. contractor citation	Nature of claim	Status
Lexington, KY	VACAB–1045 and 1046, Foster & Creighton Co., 72–2 BCA ¶ 9668.	$470 and $1,150, additional costs.	Dismissed for lack of jurisdiction.
San Antonio, TX	No Litigation		
White River Junction, VT	1. VACAB–1146, Wright & Morrissey, 76–2 BCA ¶ 11,932.	$8,274, additional costs	Appeal denied.
	2. VACAB–1147, Wright & Morrissey, 76–2 BCA ¶ 11,955.	$25,850, additional costs	Do.
San Francisco, CA	No litigation		
Los Angeles, CA	do		
Loma Linda, CA	do		
Columbia, SC	do		
Augusta, GA	do		
Bronx, NY	1. VACAB–1415, 1501, 1508, 1518 & 1521, John T. Brady & Co.	$100,000, additional costs	Suspended for settlement negotiations.
	2. VACAB–1289, John T. Brady & Co., 79–1 BCA ¶ 13,740.	Request for change order entitlement only.	Appeal denied.
	3. VACAB–1290, John T. Brady & Co., 79–1 BCA ¶ 13,761.	do	Do.
	4. VACAB–1291, John T. Brady & Co., 79–1 BCA ¶ 13,762.	do	Do.
	5. VACAB–1297, John T. Brady & Co., 79–1 BCA ¶ 13,847.	do	Appeal allowed.
	6. VACAB–1298, John T. Brady & Co., 79–1 BCA ¶ 13,848.	do	Appeal denied.
	7. VACAB–1299, John T. Brady & Co., 79–1 BCA ¶ 13,849.	do	Do.
	8. VACAB–1307, John T. Brady & Co., 79–1 BCA ¶ 13,850.	do	Do.
	9. VACAB–1327, John T. Brady & Co., 79–1 BCA ¶ 13,844.	do	Do.
	10. VACAB–1429, John T. Brady & Co., 81–2 BCA ¶ 15,301.	do	Do.
	11. VACAB–1236, AFGO Engineering Corp., 79–2 BCA ¶ 13,900.	Differing site condition-counter-claim by VA for price reduction.	Appeal denied counter-claim sustained.

RECENTLY ACTIVATED VA REPLACEMENT HOSPITAL FACILITIES—LITIGATION—Continued

VA facility	Docket No contractor citation	Nature of claim	Status
Little Rock, AR	1. VACAB-2180, Gust K Newberg Construction Co	$57,000, additional costs	Discovery.
	2. VABCA-2219, Gust K Newberg Construction Co	$863,453, defective specs	Do.

Chairman MURKOWSKI. The necessity of building a more standardized design I am sure has occurred to you. Dr. Gronvall has indicated that it is not necessarily practical in all cases. It reminds me of our nuclear power sales where we built in effect a prototype each time then watch the French walk away with the world market because they standardize a design and it has met the environmental criteria. We cannot seem to follow any pattern.

I know something about building, construction, and architectural business, and everybody likes to design something new. But standardization is a very real and proven theory. It has not been evidenced so far in any policy that we have seen emanate from the VA.

Dr. GRONVALL. I think the best example would be the nursing home prototype that we have developed in which we have a standardized prototype design for the various elements in a nursing home.

Chairman MURKOWSKI. Well, are you going to use those in the Amarillo and Tucson nursing home projects?

Dr. GRONVALL. Yes.

Chairman MURKOWSKI. Good.

In your statement you mentioned a multidisciplinary approach to project selection that brings together a number of staffs. How many people are involved and how long does that process take?

Dr. GRONVALL. I do not have that information readily available today.

Chairman MURKOWSKI. I am going to let the counsel ask it.

You may proceed. Please excuse me. Thank you.

Mr. PRINCIPI [presiding]. The question was how many people are involved in this multidisciplinary approach to project selection and how long does it usually take?

Dr. GRONVALL. I think what you are referring to is the description of the development of a—of various conceptual approaches at the early stage of development of a project.

Mr. PRINCIPI. That is indeed the consensus aspect of the planning process, am I correct, Mr. Falco?

Mr. FALCO. I am not sure if you are talking about how we prioritize projects or how we develop them.

Mr. PRINCIPI. Yes, how you develop them.

Mr. FALCO. The development level includes the clinical people, not just the administrative management, representatives from the architect's office, the Office of Construction, representatives from Central Office and the Department of Medicine and Surgery. As far as a group composition, it depends on the kind of project.

If you were doing a radiology project it would be restricted to radiology and the associated clinicians. If you are talking about a facility like Houston, it would include all the clinicians and administrative people at the medical center.

AVAILABLE

Mr. PRINCIPI. Is that why it takes 36 months to redesign a facility?

Mr. FALCO. One of the reasons that I do not necessarily look at it as a problem, except in this case, is that when you want to turn something around it takes a long time. We look at that with pride, as representing a grass roots planning level so the people at the delivery end have a greater role in deciding what kind of physical plant will be available at the completion of the project so that they can better perform the functions that are required.

That is the good side. The bad side is if you change your mind and you need to go back and do it over, it takes a long time. I do not necessarily think that it is worth giving up the benefits for having local people participate in a real meaningful way. It takes a long time because you cannot bring all the people together at one time, so these issues are deliberated in separate meetings. People with special interests in smaller groups get together and debate the propriety of the decision that is coming forward.

Mr. PRINCIPI. GAO has provided us with some information which states that there are 33 offices involved in that decisionmaking process. I can understand why it would be very difficult to reach a consensus and thus take perhaps 36 months to go through it. It just seems unduly large that it would require so many different players in the decisionmaking process.

Mr. FALCO. I am troubled because I do not think there are 33 offices in the VA. They must be using the word office to describe some other element in our organization.

Mr. PRINCIPI. They claim that there are three departments: Associate of the Administrator; Associate of the Associate Deputy Administrator for Logistics; Department of Medicine and Surgery, Central Office and Field. There are 33 separate offices involved. We can share that information with you.

Mr. FALCO. I think they are spelling out the orderly approval process. That is quite different from the deliberations associated with the decisions which are made locally. We do have an internal process where the comptrollers and auditors look at our work, and where the Chief Medical Director and the Administrator approve. That process is a normal, orderly process that allows approval of ideas. That is quite different from the development process.

Mr. PRINCIPI. Does the VA ever put in its construction contracts any incentive payment clauses for speedier construction? In other words, do you provide any incentives to the contractors to get the job completed in a more timely manner?

Ms. LIVINGSTONE. No, sir.

Mr. PRINCIPI. Have you ever considered that? Is it a viable option for the VA, just as it was for the District of Columbia when they built the 14th Street Bridge?

Ms. LIVINGSTONE. Yes. I would like to ask either Al Peter or Bill Thomas to comment on that. But I know that has been discussed before and it has not been yet implemented. I do not know if we have some contractual difficulties with that or procedural or regulatory difficulties with it or what.

But if either Bill or Al wish to speak.

Mr. PETER. Let me just make one statement on that.

My name is Albert Peter. I am the Director of the Office of Construction.

I know that when we go out on the market with a definitive set of design documents the contractor will predicate his low bid on keeping his construction period as short as possible. Any attempt on our part to accelerate that timeframe gets into the possibility of overtime considerations which are more costly to us.

On the subject of incentives, the new procurement regulations require value engineering clauses concept where the Government will share potential savings with the contractor, but we have found that those incentives have not been quite as productive once you are into the construction stage. We do our value engineering work principally in the design phase.

Mr. PRINCIPI. To go back to the prototype for a moment as well, Mr. Peter. Is there any consideration given to developing a prototype or at least standardization for certain components of a hospital for hospital construction, just as you have done for the nursing home prototype?

Mr. PETER. There are some components being considered now for standardization.

Mr. PRINCIPI. How about a prototype hospital?

Mr. PETER. Say that again?

Mr. PRINCIPI. Has consideration been given to developing a prototype for an entire hospital?

Mr. PETER. I doubt very seriously, because of the reasons that Dr. Gronvall has spoken to earlier where the practice of medicine varies so much across the country. I really defer to him for an answer on that question.

Mr. PRINCIPI. How long do you think it would take to come out with the standardization of certain components and actually implement it as part of your design?

Ms. LIVINGSTONE. The VA currently standardizes many components, including our mechanical engineering systems within a hospital system. What we do not have is an overall prototypical full design for each hospital that we can repetitively use across the country, the reason being, as Dr. Gronvall has detailed before, that each one of our medical centers has a differing function or mission. Some are affiliated, some are not. Some provide research programs, some do not. Some have nursing homes. Some have spinal cord injury services. Some have outpatients, some do not. It all varies because of our regionalized concept on delivery.

So while we can utilize standard components within hospitals and use them on a repetitive basis with maybe minor modification, I think it would be very difficult for the VA ever to fully prototype a cookie cutter approach of our hospital design.

Dr. GRONVALL. Let me expand that, if I could, from the medical standpoint. I think that when the Veterans' Administration healthcare system is reviewed by knowledgeable people from outside the Government, one of the regular criticisms is that, if anything, it is too standardized, too much centrally controlled, too much the subject of a central bureaucracy. Some of that criticism has been made here today.

I would say the trend in planning and development of medical care as well as facilities is in fact to go the opposite direction, namely, to delegate and decentralize as much as the responsibility and authority for medical program operations and planning for the future, delegate that to the individual medical centers. Medicine is practiced in different ways throughout the country. That decentralization and delegation also allows for innovation, creativity, trying new things for the future. And I believe it is a healthy trend for the VA and is in fact exactly the obverse of some of the suggestions of the questions; namely, to centralize, develop a standard hospital planned in Washington, plunked down on the scene in whatever city or town throughout the country we are talking about and enforce a rigid style of what would be by then archaic medical practice dictated out of a central office in Washington.

So I think we are really going in a quite different direction from at least the suggestion of the thrust of these questions.

Ms. **Livingstone**. Although I should add to that, too, that the VA uses very much a standardized benchmark, which is updated periodically, which is our handbook H-08-9, our planning criteria. Basically, the program officials in the Department of Medicine and Surgery articulate the operating modality delivery of particular services and then space is assigned to them. So there are standardized space guidelines: for this particular service with this particular work load you will have *x* amount of square feet. We have that for services throughout our hospital system.

Mr. **Principi**. Thank you very much. I believe the chairman might return. In the meantime, we are going to proceed with the testimony of HCA. Perhaps representatives of the VA could remain until we get a determination of whether the chairman is coming back. I believe that he is.

Thank you very much, Dr. Gronvall.

Dr. **Gronvall**. We will be pleased to.

[The prepared statement of Dr. John A. Gronvall, Deputy Chief Medical Director, Veterans' Administration, and the VA's response to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

Prepared Statement of Dr. John A. Gronvall, Deputy Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO CONTINUE OUR DISCUSSION ON THE VA'S MEDICAL FACILITY CONSTRUCTION PROGRAM. THIS MORNING'S TESTIMONY WILL FOCUS ON OUR CONSTRUCTION REQUEST FOR FY 1986 AND THE PLANNING PROCESS AND PROCEDURES WHICH RESULTED IN THE DEVELOPMENT OF THIS BUDGET REQUEST.

THE VA HEALTH CARE SYSTEM IS A COMPREHENSIVE AND COMPLEX ONE, WHICH IS MADE UP OF 172 MEDICAL CENTERS, 107 NURSING HOME CARE UNITS, 16 DOMICILIARIES, AND 53 INDEPENDENT AND SATELLITE OUTPATIENT CLINICS. THIS SYSTEM OPERATES IN A SUBSTANTIAL PHYSICAL PLANT WITH OVER 5,000

SEPARATE BUILDINGS WHOSE AGES RANGE FROM THE TURN OF THE CENTURY TO VERY RECENT CONSTRUCTION. THE VA MUST MAINTAIN A PHYSICAL PLANT CAPABLE OF DELIVERING STATE OF THE ART MEDICAL CARE; ONE WHICH CAN KEEP PACE WITH MODERN MEDICAL ADVANCES; AND RESPOND TO THE CHANGING NEEDS OF THE AGING VETERAN POPULATION. OUR CONSTRUCTION PROGRAM REPRESENTS A COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH REFLECTS THIS NEEDED CONTINUING COMMITMENT TO MEETING THE FACILITY NEEDS OF A MODERN, COMPREHENSIVE HEALTH CARE DELIVERY SYSTEM TO PROVIDE FOR OUR NATION'S VETERANS.

THE FY 1986 BUDGET REQUESTS A PROGRAM LEVEL FOR MEDICAL PROJECTS OF $712,893,000. THIS AMOUNT INCLUDES AN APPROPRIATION REQUEST FOR A MAJOR PROGRAM OF $564,700,000 WHICH INCLUDES $160 MILLION THAT IS AVAILABLE FROM PREVIOUS APPROPRIATIONS. WE ARE REQUESTING APPROVAL FOR FUNDING OF 31 MAJOR MEDICAL PROJECTS, $19 MILLION FOR THE ADVANCE PLANNING FUND TO DEVELOP FUTURE YEAR PROJECTS, $35 MILLION FOR ASBESTOS ABATEMENT, AND $20 MILLION FOR THE DESIGN FUND. WE ARE REQUESTING FUNDING TO INITIATE CONSTRUCTION OF A MAJOR REPLACEMENT FACILITY OF 927 HOSPITAL AND 120 NURSING HOME BEDS AT HOUSTON, TEXAS; REPLACEMENT OF PATIENT BUILDINGS AT MOUNTAIN HOME, TENNESSEE; AND PHASE II, THE 240-BED NURSING HOME CARE UNIT PORTION OF A MAJOR MODERNIZATION PROJECT AT PHILADELPHIA, PENNSYLVANIA. SUBSEQUENT CONSTRUCTION PHASES OF THE PHILADELPHIA PROJECT WILL INCLUDE A NEW CLINICAL ADDITION, A PARKING STRUCTURE AND CORRECTION OF FIRE AND SAFETY DEFICIENCIES. IN ADDITION, THIS BUDGET REQUEST

INCLUDES TWO NEW 120-BED NURSING HOMES, TWO REPLACEMENT DOMICILIARIES, TWO CLINICAL IMPROVEMENT PROJECTS, THREE ELECTRICAL IMPROVEMENT PROJECTS, SEVEN FIRE AND SAFETY IMPROVEMENTS PROJECTS, 10 GENERAL PROJECTS, AND TWO PROJECTS FOR SEISMIC CORRECTION. OUR MINOR CONSTRUCTION PROGRAM REQUEST IS FOR $148,193,000, FOR THE CONSTRUCTION OF MEDICAL RELATED PROJECTS. THERE ARE APPROXIMATELY 250 PROJECTS, RANGING IN COST FROM $100,000 TO $2,000,000, WHICH WILL BE FUNDED FROM THIS REQUEST. INCLUDED IN THIS REQUEST IS $10,000,000 FOR THE CONVERSION OF HOSPITAL BEDS TO NURSING HOME BEDS.

THE FY 1986 CONSTRUCTION BUDGET REQUEST IS A PRODUCT OF THE PLANNING AND DEVELOPMENT EFFORTS OF THE DEPARTMENT OF MEDICINE AND SURGERY'S PLANNING PROCESS. THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP) PROCESS SERVES AS THE PROGRAMMATIC CORNERSTONE OF CONSTRUCTION PLANNING IN THE VA. THROUGH THIS PROCESS THE VA'S 28 MEDICAL DISTRICTS, USING STATE OF THE ART PLANNING TOOLS AND GUIDANCE PROVIDED FROM VA CENTRAL OFFICE, DEVELOP PLANS TO PROVIDE NEEDED SERVICES TO THOSE VETERANS WHO USE THE VA HEALTH CARE SYSTEM. THESE PLANS WHICH IDENTIFY AND JUSTIFY MEDICAL PROGRAMS AND LEVELS OF SERVICES ARE REVIEWED, MODIFIED, IF NECESSARY, AND APPROVED IN VA CENTRAL OFFICE AND THEN SERVE AS THE BASIS FOR THE DEVELOPMENT BY EACH VA MEDICAL CENTER OF A FIVE-YEAR FACILITY PLAN - A CONSTRUCTION PLAN WHICH IDENTIFIES FACILITY REQUIREMENTS AND NEEDED PROJECTS TO CORRECT DEFICIENCIES AND TO PROVIDE THE NECESSARY PHYSICAL PLANT TO MEET PROGRAMMATIC OBJECTIVES. FROM THESE

PLANS WE DEVELOP OUR FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT WHICH IS A REPORT ON THE MAJOR CONSTRUCTION REQUIREMENTS OF THE VA MEDICAL CARE SYSTEM SUBMITTED ON JUNE 30 OF EACH YEAR TO THE CONGRESS.

EACH YEAR PROJECTS ARE SELECTED FOR DEVELOPMENT THROUGH THE ADVANCE PLANNING PROCESS. THIS EFFORT BRINGS TOGETHER, IN A MULTIDISCIPLINARY APPROACH, STAFF FROM VA CENTRAL OFFICE INCLUDING THE DEPARTMENT OF MEDICINE AND SURGERY AND THE OFFICE OF CONSTRUCTION, ALONG WITH PERSONNEL AT THE VA MEDICAL CENTER INVOLVED AND USUALLY WITH THE SUPPORT OF AN ARCHITECT/ENGINEERING FIRM, TO REVIEW IN A COMPREHENSIVE MANNER, THE NEEDS WHICH THE PROJECT IN QUESTION IS TO ADDRESS. THE EFFORT IDENTIFIES SPECIFIC REQUIREMENTS, DEVELOPS VARIOUS CONCEPTUAL APPROACHES, AND RECOMMENDS ONE CONCEPT TO BE DEVELOPED THROUGH COMPLETION OF PRELIMINARY DESIGN AND THUS BE IN A BUDGET READY STATUS FOR CONSIDERATION BY THE CHIEF MEDICAL DIRECTOR AND THE ADMINISTRATOR FOR INCLUSION IN A BUDGET REQUEST. THE PROJECTS WHICH ARE PROPOSED IN THE FY 1986 BUDGET HAVE BEEN DEVELOPED THROUGH THE ADVANCE PLANNING FUND PROCESS.

BEFORE CLOSING, I WOULD LIKE TO FOCUS ON SEVERAL INITIATIVES CURRENTLY UNDERWAY WHICH WE BELIEVE WILL MAKE MAJOR IMPROVEMENTS IN OUR CONSTRUCTION PROGRAM. WE HAVE DEVELOPED A PROTOTYPE NURSING HOME CARE UNIT WHICH WILL REDUCE THE COST OF THE CONSTRUCTION OF VA NURSING HOME CARE UNITS BY TAKING ADVANTAGE OF STANDARDIZED COMPONENT BUILDING BLOCKS, AND SIMILIARITY IN DESIGN.

SECOND, WE HAVE UNDERWAY A MAJOR CAPITAL FACILITIES STUDY OF 132 OF OUR 172 MEDICAL CENTERS. THESE STUDIES, WHICH ARE BEING CONDUCTED BY PRIVATE A/E FIRMS, INVOLVE THE COLLECTION AND ANALYSIS OF DATA ON THE PHYSICAL PLANT, INCLUDING THE BUILDING SYSTEMS, SAFETY CHARACTERISTICS, STRUCTURE AND EQUIPMENT OF THESE MEDICAL CENTERS. THIS DATA WILL ASSIST US IN PLANNING TO MEET THE FUTURE NEEDS OF OUR HEALTH CARE SYSTEM.

WE HAVE COMPLETED, AND ARE CURRENTLY REVIEWING, A NEW METHODOLOGY WITH WHICH TO ASSIST IN PRIORITIZING MAJOR CONSTRUCTION PROJECTS. THIS METHODOLOGY, WHICH HAS BEEN DISCUSSED WITH THE COMMITTEE STAFF, FOCUSES ON THE PHYSICAL AND PROGRAMMATIC CHARACTERISTICS OF EACH PROJECT AND PRODUCES NUMERICAL SCORES WHICH CAN BE CONSIDERED IN ESTABLISHING PRIORITIES. I WOULD NOTE, HOWEVER, THAT THIS SYSTEM CANNOT AND WILL NOT SUPPLANT THE NEED FOR EXECUTIVE REVIEW BY THE CHIEF MEDICAL DIRECTOR AND THE ADMINISTRATOR TO INSURE THAT CIRCUMSTANCES AND CONDITIONS WHICH MIGHT NOT BE ADDRESSED BY THE METHODOLOGY ARE CONSIDERED IN FORMULATING AGENCY PRIORITIES.

LASTLY, I WOULD LIKE TO SPEAK FOR A MOMENT ON A MAJOR STUDY BEING CONDUCTED FOR THE VA BY THE CONSULTING FIRM OF BOOZ, ALLEN, AND HAMILTON IN CONJUNCTION WITH THE A/E FIRM OF RTKL ASSOCIATES, INC. THIS STUDY IS A MAJOR EFFORT TO REVIEW AND IMPROVE UPON OUR ENTIRE CONSTRUCTION PROCESS, INCLUDING THE DEVELOPMENT OF PLANS FOR EACH MEDICAL CENTER, THE DEVELOPMENT OF SPECIFIC CONSTRUCTION PROJECTS, THEIR DESIGN AND CONSTRUCTION, AND THE MANAGEMENT, TRACKING, AND

EVALUATION OF EACH OF THESE ACTIVITIES. THE FINAL REPORT IS DUE ON APRIL 8 AND WE BELIEVE THAT IT WILL LEAD TO CHANGES WHICH WILL SUBSTANTIALLY IMPROVE OUR CURRENT CONSTRUCTION PROCESS AND PROCEDURES. I WOULD EXPECT THAT WE WOULD BE MAKING DECISIONS RELATIVE TO THE RECOMMENDATIONS IN THE FINAL REPORT BY MAY 1.

MR. CHAIRMAN, I WOULD BE PLEASED TO ANSWER ANY QUESTIONS THAT YOU OR THE OTHER MEMBERS MAY HAVE.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

As I noted in my opening statement, on January 2, I sent a letter with former Chairman Al Simpson, together with the Chairman and Ranking Minority Member of the House Committee, to VA Administrator Walters in support of the construction of a replacement VA facility in downtown Baltimore.

On February 7, the Administrator responded and noted that a task force was evaluating the situation and was to recommend "a viable and economical realistic approach" which is to be the basis of a report that he would submit to the Congress by April 1.

Yesterday, Dr. Ditzler indicated that the report would be submitted "within two weeks".

Precisely when can we expect to receive this report?

Answer 1.

The report has been completed and is currently undergoing executive review. It will be submitted to Congress in the very near future.

Question 2.

On page 13 of its written testimony submitted at yesterday's hearing, the Paralyzed Veterans of America stated, "While current VA standards for nursing home construction have not addressed the broad requirements for wheelchair accessibility, tangible progress is being made to accommodate the aging SCI veteran."

Please describe the extent to which the current VA NHCU standards provide for wheelchair accessibility and the manner in which and extent to which the VA prototype for nursing home care construction will do so?

Answer 2.

Current VA NHCU standards exceed Uniform Federal Accessibility Standards (UFAS) by providing that all new construction be totally accessible. The entire NHCU prototype is completely (100%) accessible to, and usable by disabled persons. This has been verified by the VA Architectural Accessibility Compliance Officer whose primary responsibility is to review all VA construction to ensure access to and use by disabled individuals including special populations using VA facilities. The VA NHCU prototype provides two two-bedroom modules in each 60-bed unit that are enlarged to permit maneuverability by SCI patients. The adjoining toilet room has also been specially modified to allow SCI patient accessibility. Additionally, all patient use areas have been made accessible to SCI patients.

Question 3.

In the VA's FY 1985-1989 Five Year Medical Facility Construction Needs Assessment, submitted last June, two California projects for which funding was scheduled in FY 1986 were identified -- the correction of laundry deficiencies in West Los Angeles and the construction of a 120-bed nursing home at Martinez. However, in the VA's FY 1986 budget submission, these projects were not included. In the case of each project, please provide for the record an explanation of the justification for not including the project in your FY 1986 proposal and a revised timetable for the project.

Answer 3.

The 1986 budget was prepared within the overall context of a major effort to reduce federal spending and, therefore, a number of projects planned for FY 1986 were not included. We anticipate that both these projects will be considered for inclusion in the FY 1987 budget request.

Question 4A.

With respect to the VA's letter of March 20 regarding the progress of the comprehensive study of the VA's organization and procedures for constructing health care facilities, being conducted by Booz, Allen and Hamilton, Inc. and RTKL Associates, could you describe the recommendations that were made that resulted in the projects's scope being expanded and its cost increased by $380,000?

Answer 4A.

Our top management recommended that additional tasks be added to the statement of work--tasks that were within the original scope of the study. Contract modification number one, in the amount of $129,080, added on-site data collection at 17 VA medical centers and nine architect/engineering firms. On-site interviews were recommended to replace telephone interviews which were required in the study's request for proposal. The on-site interviews were added because on-site data collection improves the quality and depth of the data collected. Contract modification number two, in the amount of $125,814, increased from 15 to 30 days the period of time between the submission of the draft and final deliverables for phases II and III of the study. It also expanded the contractor's detailed analysis, to include the minor miscellaneous, programs.

The changes were made to allow a more comprehensive review of each draft deliverable and to intensify analysis of the minor construction program since it accounts for about 40 percent of the construction workload budget. Contract modification number three, in the amount of $ 130,569, added a separate, stand-alone assessment of the strengths and weaknesses of the delegated versus non-delegated nursing home care unit design and construction projects. This modification was made to address nursing home issues in the context of the larger study.

Question 4B.

The Administrator's letter indicates that the study is expected to be completed by April 8, and that we will be briefed on the study's findings and recommendations after the VA has had an opportunity to review it. How long do you contemplate the VA's review will take?

Answer 4B.

The report from the contractor has been received and is currently undergoing review by the appropriate staff offices. It is anticipated that the review process will be completed in the near future.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ROBERT T. STAFFORD, A U.S. SENATOR FROM THE STATE OF VERMONT

Question: 1. The Permanent Research Building (PRB) at the White River Junction VA Medical and Regional Office Center was first approved for construction in 1979 at an estimated cost of $1,131,000. Presently, research is conducted in four quonset huts. In the Five Year Medical Facility Construction Needs Assessment, the PRB is scheduled for construction in FY 1986 at the estimated cost of $7,100,000, over six times the original estimate. It is my understanding that this building was not included in the President's Budget request for FY 1986. Why ?

Answer: In the development of the budget request a decision was made within the context of the President's freeze plus policy not to request funds for projects which were designed to expand the VA system. Exceptions were made only in the replacement and modernization and nursing home categories. The project at White River Junction, Vermont was judged as expansionary and as such it was not included in the budget.

Question: 2. When do you expect to request funds for this building?

Answer: This project will be a consideration in the development of the fiscal year 1987 budget request.

Question: 3. Have those programs which were approved for construction in FY 1986 but not included in the President's Budget Request been notified? If not, when do you plan on notifying them?

Answer: VA Medical Centers have been notified of those major construction projects which were included in the President's Budget Request.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

QUESTION: I would like to know all of the Architectural and Engineering costs for all the Veterans Administration Hospitals built since 1970.

ANSWER :

A/E COSTS FOR HOSPITALS BUILT AFTER 1970

MEDICAL CENTER	ARCHITECT/ENGINEER COSTS
Columbia, Missouri	$ 467,742
San Diego, California	1,672,516
Tampa, Florida	979,868
Northport, New York	841,120
Lexington, Kentucky	518,297
San Antonio, Texas	1,318,565
White River Junction, Vermont	297,610
San Francisco, California	707,535
Los Angeles, California	2,779,886
Loma Linda, California	2,692,388
Columbia, South Carolina	2,287,910
Augusta, Georgia	2,040,150
Bronx, New York	7,927,700
Little Rock, Arkansas	5,462,000
Martinsburg, West Virginia	3,500,936
Bay Pines, Florida	6,610,000
Richmond, Virginia	6,578,000

Question: In each case, I would like a one paragraph description of the design of the hospital structure, including the hospital's mission, the number of beds, and the number of veterans it is tasked to serve.

Answer: The attached material provides the information requested.

AUGUSTA, GEORGIA

The Downtown Division of the Augusta, Georgia, VA Medical Center is a seven-story metal-curtain-wall on steel frame building with a separate central energy building to the east. It was completed in 1980. The medical center sits on 19.9 acres and is affiliated with the Medical College of Georgia, to which it is directly connected by an enclosed pedestrian bridge.

This acute medical, surgical, and psychiatric facility has an authorized bed capacity of 420 beds. This medical center serves a total veteran population of 85,040.

BAY PINES, FLORIDA

The Bay Pines center replaced several obsolete structures with a new five-story building in 1983. The building, designed in accord with the VA Hospital Building System, has a reinforced concrete frame surfaced with precast concrete panels and some poured-in-place concrete walls. This building, a new domiciliary, two 120-bed nursing homes, and the remaining older structures comprise the medical center. They sit on 337 acres of land.

This primary care facility of medical, surgical, psychiatry, nursing home care and domiciliary services, has an authorized bed capacity of 670 hospital, 240 nursing home care and 200 domiciliary beds. This medical center serves a total veteran population of 413,680.

VAMC, BRONX, NY

VAMC, Bronx, NY is a 702-bed facility that provides general medical, surgical and psychiatric services to Veterans of the New York area. The new replacement hospital was completed in 1980. The nine-story structure is a concrete frame with metal exterior walls. A 120-bed nursing home care unit, attached to the hospital building by an underground corridor, is now under construction and will be completed this year. The medical center is affiliated with the Mount Sinai School of Medicine.

This acute medical, surgical, psychiatric and nursing home care unit facility has an authorized bed capacity of 702 hospital and 120 nursing home care beds. This medical center serves a total veteran population of 1,072,650.

VAMC, COLUMBIA, MISSOURI

The Harry S. Truman Memorial Veterans Hospital at Columbia, Missouri was opened in April 1972. This facility serves a veteran population of 108,833 with 406 hospital beds and 54 nursing home beds.

A CAT Scanner was activated in the Radiology Department in January 1985. The seven-story, brick exterior and reinforced concrete structure is located on 19 acres adjacent to the University of Missouri Campus. The hospital is heavily affiliated with the University's Schools of Medicine and Nursing.

This acute general medicine, surgery, psychiatry and nursing home care facility has an authorized bed capacity of 398 hospital and 54 nursing home care beds. This medical center serves a total veteran population of 107,510.

COLUMBIA, SOUTH CAROLINA: Built In 1979

The Columbia, South Carolina Medical Center is a five-story brick building on a structural steel frame. A 120-bed nursing home care unit was added in 1980. The medical center is affiliated with the University of South Carolina School of Medicine, which occupies several older buildings on the 94.2 acre site. A number of other older buildings are still used as part of the VA medical center.

This acute medical, surgical, psychiatric and nursing home care unit facility has an authorized bed capacity of 460 hospital and 120 nursing home care unit beds. This medical center serves a total veteran population of 200,800.

VAMC, LITTLE ROCK, AR

The two facilities of the VAMC, Little Rock area are John L. McClellan division and North Little Rock division. The 505-bed McClellan facility is an eight-story steel frame building with brick exterior walls that was built as a GM&S replacement for the old 1950 VAMC on Roosevelt Rd.

VAMC, North Little Rock is a four-story steel frame building with brick and concrete exterior walls. The 1000-bed facility has 200 nursing home care unit beds.

This acute medical, surgical, and psychiatric facility has an authorized bed capacity of 505 hospital beds. This medical center serves a total veteran population of 168,580.

LEXINGTON, KENTUCKY: Completed In 1973

The Cooper Drive Division of the Lexington VA Medical Center was completed in 1973. The seven-level brick building on a reinforced concrete frame sits on 4.8 acres of land directly connected to the University of Kentucky Medical Center, with which it is affiliated. A clinical addition is to be built on the south side of the 1973 building in 1986.

This acute medical, surgical and psychiatric facility has 348 authorized hospital beds and serves a veteran population of 92,670.

VAMC, LOMA LINDA, CA

The VAMC was completed in 1977, the first hospital designed and built according to the VA Building Systems concept. The structure is a four-story steel frame building with concrete shear walls. The exterior skin is stucco. The center has a 60-bed nursing home care unit and a new 60-bed nursing home care unit addition is now under construction.

This acute medical, surgical, psychiatric, and nursing home care facility has an authorized bed capacity of 440 hospital and 60 nursing home care beds. This medical center serves a total veteran population of 1,526,970.

VAMC, LOS ANGELES, CA

The hospital is a six-story steel frame structure with a stucco exterior face, completed in 1977. The building is similar in design and appearance to VAMC, San Diego and has interstitial spaces between floors.

This acute medical, surgical, psychiatric, nursing home care, and domiciliary facility has an authorized bed capacity of 832 hospital, 357 nursing home care, and 300 domiciliary beds. This medical center serves a total veteran population of 1,526,840.

VAMC, MARTINSBURG, WV

The Martinsburg VAMC consists of a general medical and surgical hospital, nursing home care unit and domiciliary. The new hospital building is a steel and reinforced-concrete structure with brick facing completed in October 1983. New domiciliary and nursing home structures, plus a number of older buildings, also comprise the medical center. Through the Deans Committee, the center is affiliated with the George Washington University, Georgetown University and Howard University schools of medicine. It serves a total of 117,000 Veterans annually.

This primary care facility of medical, surgical, psychiatric, nursing home care, and domiciliary services has an authorized bed capacity of 357 hospital, 120 nursing home care, and 540 domiciliary beds. This medical center serves a total veteran population of 115,360.

VAMC, NORTHPORT, NY

VAMC, Northport, NY is a 920-bed general hospital affiliated with the medical school of the State University of New York. The four-story main building is of brick and was completed in June of 1972. Numerous older buildings also comprise the medical center, and construction will start on a new 120-bed nursing home later this year.

This acute general medical, surgical, psychiatric, and nursing home care facility has an authorized bed capacity of 960 hospital and 120 nursing home care beds. This medical center serves a total veteran population of 1,072,650.

VAMC, RICHMOND, VA

VAMC, Richmond VA is an 820-bed replacement hospital constructed in 1983. The five-story structure is concrete with exterior walls of glass and brick. It includes a 120-bed nursing home care unit and a 120-bed spinal cord injury unit. The medical center is affiliated with the medical college of Virginia - Virginia Commonwealth University.

This acute medical, surgical, psychiatric, and nursing home care facility has an authorized bed capacity of 694 hospital and 120 nursing home care beds. This medical center serves a total veteran population of 213,050.

VAMC, SAN ANTONIO, TX

The building, completed in 1973, is a seven-story steel frame structure with brick exterior walls. The building has interstitial spaces between floors to accommodate all power and utilities and to allow workmen to change or service mechanical and electrical systems without disturbing patient care operations. A 120-bed nursing home care unit addition is now under construction.

This acute general medicine, surgery, psychiatric and nursing home care facility has an authorized bed capacity of 704 hospital and 120 nursing home care beds. This medical center serves a total veteran population of 279,940.

VAMC, SAN DIEGO, CA

The 1972 building is a six-story steel frame structure with metal panel exterior walls. It has interstitial spaces between floors to accommodate all power and utilities and to allow repairs or adjustments to support equipment without disturbing patient care operations in the rooms below. The center has a 60-bed nursing home care unit and a 30-bed spinal cord injury unit is now under design.

This acute general medical, surgical, psychiatric, and nursing home care facility has an authorized bed capacity of 701 hospital, 60 nursing home care beds. This medical center serves a total veteran population of 765,420.

Mr. **Principi**. We will receive testimony from Mr. Tom Batey, vice president, planning and construction, Hospital Corporation of America; and Dr. David West, director, special projects, Hospital Corporation of America.

Welcome, gentlemen. How would you like to proceed? Mr. West?

TESTIMONY OF DR. O. DAVID WEST, DIRECTOR, SPECIAL PROJECTS, HOSPITAL CORP. OF AMERICA, NASHVILLE, TN, ACCOMPANIED BY TOM BATEY, VICE PRESIDENT, PLANNING AND CONSTRUCTION

Dr. **West**. I am David West. I would like to go first if that is OK with the chair.

Mr. **Principi**. Fine.

Dr. **West**. Hospital Corp. of America is honored to have this opportunity to testify before this esteemed body.

First of all, I would like to say that we are not unmindful of the dilemma which this committee and the VA faces, as well as the U.S. Government really. The dilemma of how to provide quality, cost-effective health-care services, not only to our veterans, but to all the citizens of our Nation, is a challenge that really requires the best coordination and ideas of our Government and nongovernmental citizens, and it requires that those ideas be effectively deployed.

The reason we at HCA view this as a national problem rather than just a problem of the VA is that in 1984 10.7 percent of the gross national product of this country went to health care. Yet, we still have indigents not getting adequate health care; we still have veterans requiring additional health care; we have a health-care system that, albeit, the finest in the world, has over capacity in certain parts of the country and under capacity in others.

For example, although the Gemanac report projects a surplus of 90,000 physicians by the year 2000, there are still many people in rural areas of this country that will have inadequate health care. Similarly, many communities will probably have to close their local hospitals because of underutilization in the coming decade. We at HCA are poignantly aware of this dilemma and the challenge to our Nation.

What can we in the non-Government sector, the private sector, do to address the challenges and problems that the VA faces in attempting to deliver quality health-care services to our Nation's veterans? In an environment with shrinking financial resources available from the Federal Government, and in an environment where the regulations and procedures that have built up through the years in the VA, where the resulting processes are so complex and so burdensome that a hospital that is needed today may not be built for another 8 to 10 years, with a loss of maybe $150 million in inflation alone, and even when that facility is built the cost far exceeds the competitive cost because of these delays that are involved in working the process through.

We find that some of the VA hospital beds cost twice as much as those built in the private sector to construct, and more to operate when you consider the long length of stay and the type of care that is given. We find that some of the VA nursing home beds cost five times as much to build and twice as much to operate as in the non-Government sector.

So on the one hand it is not surprising given the cumbersome bureaucratic processes that the careerists and dedicated people at the VA must follow. On the other hand, the real issue here today seems to us to be whether there are more cost-effective ways of satisfying the needs of the veterans through expanded sharing agreements with non-Government hospitals.

Now, according to the Houston Hospital Council, the general hospital census in Houston has experienced a precipitous drop in the last 2 years to a January 1985 level of 56.7 percent. These are not HCA numbers; these are from the Houston Hospital Council. This 56.7 percent occupancy leaves 167,733 bed-days a month empty, or 5,410 beds per day empty in the Houston area. Now, this would equal a 6,760-bed hospital at an optimum occupancy level of 80 percent.

This dramatic decline is because of declines in the use rate—approximately 1,110 patient-days per 1,000 in 1982, down to 870 patient-days per 1,000 in 1984. It is because of changes that are occurring in the delivery of medicine that encourage outpatient surgery and outpatient treatment; it is because of the impact of DRG's and the entry of real tough competition in the marketplace today.

This above example about Houston is repeated throughout the country. We have experienced in our country, and I think almost every community has throughout the entire nation, have experienced this dramatic decline of around 10 percent in census. We anticipate that that decline will continue; the census may go down another 10 or 15 percent over the next couple of years as the practice of medicine continues to evolve.

Now, speaking from a nongovernmental position, the thousands of nongovernmental hospitals in this country have excess capacity. That excess capacity is growing. That fact requires me as a businessman and a citizen to ask some significant questions to our legislators.

One. Does it make sense to continue to build more beds in the Government system when there are more than an adequate number of quality beds available locally in a parallel non-Government system?

Two. Are we not all trying to accomplish the same task to provide cost-effective quality health care for Americans?

Three. Should we continue to add to the physician surplus that everyone already admits is going to be difficult by 1990?

Four. Can the veterans benefit, actually benefit, from sharing? Can they benefit by the convenience of using a local hospital? By not having to wait until space is available? By having a choice of where they go? By having continuity of care with a personal physician?

Five. Should the taxpayer pay for those hospital beds three times? Ladies and gentlemen, most of the beds in this country that were built since the early 1950's were built with Federal and State Hill-Burton funds, so they have been paid for with Government money. Now, 40 percent of all the beds in this country are occupied by Medicare patients to the tune of over $300 billion a year; that means the maintenance of those beds is funded by Medicare. Now the gentlemen in the VA, in trying to accomplish their lofty goal of providing a high quality health-care facility to replace the one in Houston, is asking approval to go out and borrow another $250 to probably $275 million, because it costs money to get money today, and that $250 million even if it could be built for that probably would end up being 10 percent higher or around $275 million, because the money is not just sitting there, as all of you know, waiting. There is a cost to borrow money.

So what they are doing is asking you to replace that facility at an additional cost of maybe $275 million.

Six. Is this discussion today to justify building a facility or is it to consider the most cost-effective and efficient way to provide quality health care for the veterans in the Houston area?

Finally, seven. Should any system, the VA included, plan in a vacuum without considering the effects of their actions on the remainder of the system? If you look at Houston, there are VA hospitals and there are all sorts of other Government and non-Government hospitals in that area. Should they not be planning together and sharing expensive resources?

Gentlemen, the Government cannot fund everything the VA or anyone else wants, and it will probably get worse. We are facing some tough budget problems with a huge deficit. There is a need and a role for the VA in our health-care culture. The VA provides health care for 12 to 15 percent of the veterans in this country. But there is also a role for the non-VA hospitals who provide health care for 85 to 88 percent of the veterans in this country. So what we are suggesting is that we team up together, resolve problems, and consider the very best of both systems for the veteran. Let's include in our discussion quality, cost-effectiveness, convenience, sharing, and put together a planned system that uses the best of both systems and will save money for our Government.

In other words, let's solve both systems' problems by piloting some innovations. Let's begin to work together. This segregated, expensive duplication of systems in this country with a group of VA hospitals, a group of Army hospitals, a group of Navy hospitals, a group of Coast Guard hospitals, a group of private hospitals, these are duplicated services. This must not continue. We cannot afford that anymore. It is in the best interest, I maintain, of the 30 million veterans in this country to move forward into a new era of cooperation and modernization.

I would like to ask my colleague, Tom Batey, to comment specifically on the proposed Houston project.

Mr. BATEY. Mr. Chairman, if I may take just a few moments establish a little historical information about HCA and its design and construction program, since that is my primary responsibility with the company.

Beginning in 1968 and through this current year 1985, HCA will have completed 128 complete new hospitals with a total of 15,413 beds. In addition to those new facilities, expansions of existing hospitals have brought our total construction program during this period to 21,074 beds. Realizing, of course, these are not VA type hospitals. They vary in size from 40 beds to 400 beds. So there are different types, different locations, and different services provided.

During 1983 this volume of construction included 14 complete new hospitals with 1,941 beds. Total dollar expenditure in 1983, $465 million. In 1985 we will also complete 14 new facilities, approximately 1,800 beds in those new facilities, a total of 2,219 beds and $490 million expenditure.

The projects completed in 1984 cost an average--and this cost includes everything that goes into the construction of that facility from land through toothpicks in the cafeteria.

Chairman **Murkowski** [presiding]. And site preparation?

Mr. **Batey**. Yes, sir. Equipment——

Chairman **Murkowski**. Completed project cost?

Mr. **Batey**. Equipment, site, ready to operate, ready to accept patients. That cost for 17 hospitals, 2,080 beds in 1984 was $150,000 per bed.

We just opened a 299-bed hospital this past Sunday at that same cost per bed, including in this particular instance 100 acres of land in the site.

Chairman **Murkowski**. What is your professional opinion on the ability of this type of hospital to meet the needs of the veterans? Please take into account the previous testimony which indicated that there are certain additional considerations to meet veterans' unique needs?

Mr. **Batey**. Sir, I have had only a brief view of the preliminary plans for this facility, and I would, obviously, not get into detailed discussion about the designs. There are some basic concerns that we would have as a private hospital development operator. No. 1, in building a 1,000-bed hospital, I can conceive of no circumstances where our company would consider building a facility this large for a number of reasons. Obviously, the logistics not only of providing the staff and services to support that type of size of facility would be tremendous.

Chairman **Murkowski**. Are you saying it is cheaper and more efficient to build two small hospitals as opposed to one large one?

Mr. **Batey**. I cannot prove that by numbers, but that is our philosophy of our company. We have chosen to build hospitals—the largest that we have built thus far is approximately 400 beds. We do have some larger than that because they have been expanded, but we do not consider beginning with a facility of that size, primarily, I might add, for the convenience of the patient because the patient in a facility of this sort tends to be lost in the maze. And the type of personal care that we espouse in the delivery of health care, my company, does not give that in a facility of this sort, is our opinion.

Also, I would, with regard to the planning of this facility, there is some concern that I would have about combining all of the services that are indicated on the plans. For example, from nursing home beds through the spinal cord injury unit, emergency facilities as well as large outpatient service areas. Again, the concern being the momentum of the operation of a facility of that size and the support that is required in not only staffing but also in the systems itself, whether it be elevators or mechanical systems, electrical systems, so forth, must be very sophisticated in a facility of that sort. And the operation of those systems and the staffing of that facility tends to, in our opinion, outweigh the concern for the individual patient in the care that is being delivered.

Mr. WEST. Yes, sir.

Chairman MURKOWSKI. You indicated in your testimony that the private sector or the non-VA hospital provides health care for 85 to 88 percent of the veterans of this country. Is that inpatient, outpatient, or the whole ball of wax?

Mr. WEST. That is according to a 1982 study of the VA statistics from their annual report. Comparing that to the 1980 census figures indicated that the overall dollars spent and the overall units of service, inpatient, and outpatient, indicated that the Government VA hospitals, specifically, saw 12 to 15 percent, and the nongovernmental hospitals saw the large bulk of the veterans.

Chairman MURKOWSKI. When you say "saw" do you mean provided care for?

Mr. WEST. Yes, sir.

Chairman MURKOWSKI. Mr. Principi, would you write a letter to the Veterans' Administration asking them to comment on those figures?

Mr. PRINCIPI. Sure.

Chairman MURKOWSKI. They are quite startling, needless to say.

Page 4 of your testimony indicates your willingness to share your knowledge with the Veterans' Administration. Are you currently working with the VA to exchange ideas pertaining to construction?

Mr. WEST. Not at this time. We have——

Chairman MURKOWSKI. Has the VA requested you to do so?

Mr. WEST. Yes; I spent 1 year with the Veterans' Administration on sabbatical in 1982 and reviewed 57 projects with some of these ladies and gentlemen here. Of the 57 construction projects reviewed, we found 35 were good projects and should go ahead, 21 were not complete and one was unnecessary.

At this time we do have two contracts that I am aware of with the Veterans' Administration; one is for ambulance service in the Northwest, and one is for ancillary services for patients in southern Texas. But the VA has made no overtures to do any pilots; neither have we made any overtures to them at this point.

Chairman MURKOWSKI. It seems to me a kind of a chicken and an egg deal.

Mr. WEST. However, we would like to——

Chairman MURKOWSKI. Nobody wants to court the other one, is that right?

Do you think that it is just coincidental that the VA has not purchased or leased existing hospitals? Do you believe that there is an inherent commitment within the VA that their charge is to build new facilities?

Mr. WEST. I think in the past that their opinion was that that was their commitment, up until a couple of years ago. I do think that now they are thinking seriously about doing some innovative things. And I think time will tell if they actually proceed with such things as trying to share with planning with local community hospitals and with Department of Defense hospitals and with trying to put together some ideas to lease space.

We have discussed in the past such items as the construction of nursing home facilities. HCA owns a significant part of Beverly Enterprises that does a lot of business with the Veterans' Administration. And if it is true, based on the numbers that we saw back in 1982, that it does cost five times as much to build a nursing home bed and twice as much to operate that bed—and the Veterans' Administration agreed with those numbers at that time—if that is still true it would seem to me that that would be a major area where we might work out some sharing and have someone build those beds and operate them for them.

The same thing would apply, we think, in some areas for hospital care. We would not be willing to say that in all areas HCA would have all the answers, because that would not be true.

Chairman MURKOWSKI. How about the quality? Is there a quality difference?

Mr. WEST. I do not think there is one iota of quality difference between comparable hospitals anywhere in this country today. Most of the hospitals are accredited and they are licensed and all of the physicians meet the same criteria and graduate from the same medical schools. If a physician graduates from Harvard Medical School and practices at the VA in Boston, or practices at Parkview Hospital in Nashville, TN, it is not going to make a bit of difference in the way he practices.

Chairman MURKOWSKI.You contend that, in your opinion, there is going to be a decline in occupancy for various reasons which you have already elaborated on. There is application of that line of reasoning when one considers the needs the VA has to meet and foresees vis-a-vis the need for replacing facilities that are obviously old and no longer capable of efficiency. It may be implied that because the VA is building, they are building new facilities, and that is not always the case. In some cases they are building to replace. Yet you contend that it is likely that there will be a decline in the demand for that particular type of care. Is there evidence, in your opinion, to support that given the VA's projections?

Mr. WEST. Well, based on the studies I was referring to a few moments ago in 1982, and on the 1980 census figures, I saw a big bulge of required care for veterans from the years 1990 to 2000. On the other hand, after that the demand dropped off rather dramatically. Again, the practice of medicine is changing so dramatically, and so many things are being done now by outpatient surgery, that the number of patients that are admitted have dropped dramatically, about 10 percent in the non-Government sector throughout the United States in the last year. We think it is going to drop another 10 to 15 percent. And there's a couple of reasons for that.

First of all, physicians do not admit you for everything today that they did 10 or 15 years ago, not nearly the things that they did. And there are some reasons why they do not. DRG's is a good part of that; insurance companies have gotten much tougher about payment; companies, about 60 percent of the Fortune 500 companies, have added copays and deductibles to their employees.

And a Rand study done last year showed that if you charged, made your employee pay for about 10 percent of his health care, he only uses a fraction of the health care he used when it was 100 percent free. That is a real dramatic change.

In HCA we put together a pilot project, tested it in Nashville, and the result was a 20-percent drop in the increasing cost of our own employees, which were costing us almost $80 million a year.

So all of these things are adding up to a declining census throughout the country. A couple of things could affect this rather dramatically. And I am sure the gentlemen in the VA would agree with this. If the Medicare Program raises the deductibles considerably so that a lot of older veterans cannot afford it, they will flood to the veterans' hospitals. If the Government does something to permit only those who need free care to use the veterans' hospital, a large number of veterans will swing over to the private sector.

We do not know what is going to happen. So what we are saying is that the VA, instead of planning in a vacuum, and the non-Government private hospitals, instead of planning in a vacuum, and the military hospitals, instead of planning in a vacuum, should get together and recognize that PPO's work, HMO's work, IPA's work; all these new kinds of health-care systems do work. And let's start exploring those, plan to share and work out a lot of solutions to the health-care cost in this country. I just do not think there is any alternative left. I do not think that any group can continue to survive on their own without talking to the other groups.

It is time to do it now, not in 1995, but now. Because the way the Government works, and particularly in the VA bureaucracy, if we start talking now it will be 1995 before anything occurs.

Chairman **Murkowski**. It is very interesting to reflect on the recommendation. Implementation is obviously something else. That is the responsibility of this committee and the Congress. We need to reflect on whether it is necessary to either change the VA procedures or leave them the same. However, in fairness to the VA, there is continuing awareness of the necessity to maintain quality care and to keep pace with the technological advancements in medical service. It is always difficult to compare a Government operation with a private sector operation because the motivation is based on two entirely different principles.

While we strive to achieve greater efficiency within the VA, the realization is that it is not profit motivated. It does not have to amortize its investments as the private sector does, therefore, you cannot compare the two. The very nature of Government, which is a service sector, grows on its own and feeds off itself, so to speak, and its base is to expand and provide ever greater and more services.

The question of how you harmonize the efficiency of the private sector with Government has probably been debated around here for a long, long time. Many words have been spoken and recommendations made.

My question to you gentlemen is, you have made general recommendations, you have made comparisons, you have indicated that you, indeed, treat 80 to 85 percent of the veterans in the private sector. I assume, generally speaking, you speak for the private sector, but, why are you so alone? I hear from all kinds of interested groups with regard to this, but here comes two people from the private sector. I do not hear from the rest of the hospitals in this country that are experiencing a void of available beds. I do not know how many hospital associations there are in this country, but it seems to me that when they come in and lobby in my office for other things, why, there is a lot of them but I do not see many of them here.

Mr. WEST. Well, Senator, they just have not gotten around to it yet.

Chairman MURKOWSKI. I see.

Mr. WEST. We did not mean to slight you. They are going to be here.

I am on a congressional panel now looking at the Department of Defense military health-care system. And Mr. Alex MacMahon, president of the American Hospital Association, and Dr. Jim Sammons, president of the AMA, are also on that panel with me. And I can assure you that they agree with what is occurring.

Chairman MURKOWSKI. You have been a consultant to the VA, you have watched the process, now you are in the private sector and obviously have to produce or you would not be able to remain in there.

Mr. WEST. Absolutely.

Chairman MURKOWSKI. Somebody else would take your place.

In all fairness to the dedication and commitment to the people within the VA, who are trying to make this thing work within the bureaucracy, which I'm sure they find frustrating have you any concrete suggestions about where they might start? The idea of moving the entire immensity of the beast from one side to the other does not interest me, because that is not going to be done. The question is, are there some viable pieces that can be examined systematically and get the recognition of the VA that, yes, there is a better way to proceed? It may be modest in its intent but it can be substantive if applied to the planning process of the VA?

Mr. WEST. Well, Senator, I think what we would want to do would be to try to develop a win/win situation with the people in the VA. We would not want this to be an arbitrary or a combative approach.

Chairman MURKOWSKI. Are you prepared to do this without a contract from the VA?

Mr. WEST. Yes. We are prepared to sit down with the representatives from the VA and——

Chairman MURKOWSKI. At your own expense?

Mr. WEST. At our own expense. To discuss this openly and candidly and to try to develop perhaps 10 possible pilots, concentrate on the best 2 or 3 of those pilots to do things that——

Chairman MURKOWSKI. When you say "pilot" are these hospitals or ideas?

Mr. WEST. Well, you might have one of those pilots that would be a hospital. Another might be using a local facility and comparing some costs and really working out the formula for the comparison ahead of time. Another might be instead of flying a patient 200 or 300 miles to get his blood work, let him get the blood work in the local civilian hospital and save some money.

Chairman MURKOWSKI. What is in it for your organization?

Mr. WEST. What is in it for us? Long-term, we would like to see some of those VA patients use our hospitals. Very clear and open.

Chairman MURKOWSKI. Have you initiated such a request to the Veterans' Administration?

Mr. West. No, sir, we have not.

Chairman Murkowski. Do you intend to?

Mr. West. I hope so. I cannot answer that question specifically until July of this year.

Chairman Murkowski. What happens in July?

Mr. West. In July we will make that decision. We have a board of directors, Senator, as I am sure you realize, and we must get approval for these sorts of things. Certainly there would be no problem with us committing to talk. And, it does not take us 5 years for this kind of a commitment, it would take us about 10 minutes.

Chairman Murkowski. What is the likelihood of them accepting your offer for free assistance in the area of construction planning?

Mr. West. There are some very good people in the VA, some people who have some serious problems who would welcome help.

Chairman Murkowski. How long do you suppose it would take the VA to make up their mind on whether they want to accept that?

Mr. West. Longer than July.

Chairman Murkowski. That is why I was hoping you would extend it ahead of time so we would not have to wait until July to find out whether the VA wants to take you up on it.

Mr. West. I would like to have a meeting with the Administrator of the VA and whatever staff he wishes within the next 30 days and see if they are willing to do it, and maybe try to isolate within the next 6 to 8 weeks those 10 pilots.

Now, I am not sure that the gentlemen from the VA can move that quickly because they have to talk to a lot of people. It, you know, slows things down. And they must consider rules and regulations which we are not bound by because we can write our own rules as we go along.

When I said July date, I was talking about a major commitment.

Chairman Murkowski. I would ask Mr. Principi to stay in communication with you because we would be interested in knowing the outcome of your meeting with the VA and the extent of interest which they expressed. We can find out from Mr. Harry Walters as well what his views are.

I think you are absolutely correct in your assessment. It is time to look for alternative methods of providing high quality care. We must begin to examine some innovative ideas. It is great to have a list of 10 new hospitals, but the reality is that we are only proceeding with 4 of them this year. I am reminded of what goes on in the Environment and Public Works Committee which I was a member of for some time. We deliberated extensively on projects for deepening harbors and building locks and various public processes throughout the United States. We voted diligently on them and then they never reached an appropriations stage. We were left with a whole roomful of authorized projects. The realities of that are evidenced throughout the budget process. Today where we are cutting, cutting, and cutting. The VA is also in that same position.

Yet, the projections are that the needs are going to increase and that the planning process is inadequate to meet the growing needs. We have an obligation under the law to provide certain services and we must realize that we are going to have to look to alternative methods. Some see that as a heresy because it is a departure from the norm. I think the obligation is in the quality of service. It has to be provided and the question is, how will we continue to provide it?

Mr. **Batey**. Mr. Chairman, if I may, I would like to comment briefly on the subject of prototype designs which were discussed earlier.

Chairman **Murkowski**. Excuse me.

Mr. **Batey**. Reference has been made to prototype hospital plans in some detail here today. I might just briefly explain how we approach that question in planning.

We do have prototype designs, but those designs are for individual spaces within our hospitals. We have a standard plan, including all of the equipment, for each room in a hospital of any size, several hundred of those spaces. Our designs then, as we prepare the preliminary design for an individual facility, incorporates whatever use of those spaces. Obviously, a patient bedroom is no different whether it is in a 50-bed or a 500-bed hospital, that individual room. So the use of prototype designs for individual spaces facilitates the overall planning process.

It is our opinion that about 90 percent of what goes into design of an individual hospital is standard. Therefore, we concentrate on the other 10 percent rather than 90 percent in developing those designs.

Chairman **Murkowski**. I have to go over to the Foreign Relations Committee. I regret not being able to conclude.

I basically finished my questioning. I want to thank you for being with us. Mr. Principi may have additional questions. But more specifically, we will look forward to hearing how you come out with your July proposal.

Thank you, gentlemen.

Mr. **Principi** [presiding]. I just have a few additional questions to tie up some loose ends.

Regarding the excess beds in Houston, do you believe that there will be an excess in Houston in the year 1990 and the year 2000?

Mr. **Batey**. Certainly; I think that excess is going to continue. Now, some of those facilities, as Dr. West mentioned, may go out of business depending upon the severity of the decline in occupancy. They may not be economically able to stay in business. So that could remove some of those excess beds from the market in that area.

Mr. **Principi**. The Senators from Texas have both stated that redesigning the Houston medical facility to reduce the number of beds would cause an unreasonable delay of 2 to 3 years. Can you address the time and cost involved in redesign generally, and perhaps from your knowledge of the design of Houston, how it would relate to the Houston project?

Mr. **Batey**. I would not attempt to be too specific about the design of that facility, I am not that familiar with it. However, I can comment on our own planning process and the time that we normally take to design a complete new facility. And that is an average of approximately 6 months, and that includes preliminary design as well as complete working drawing documents.

So the timeframe that was referred to seems inordinately long to us to redesign an existing facility when we could in our normal practices start from scratch and design within 6 months.

Mr. PRINCIPI. You previously stated that your largest hospital was 400 beds. The proposed Houston hospital is in excess of 1,000, would that, if you were to design a hospital of that size, increase the length of time to design?

Mr. BATEY. If you double the time, which would not in my opinion be required, you are still only talking about 12 months versus 24 to 36, as I have understood.

Mr. PRINCIPI. Mr. Batey, is there an ideal design for the most functional, cost-effective hospital?

Mr. BATEY. I do not think there is any information available to substantiate an ideal design. And, as I mentioned earlier, we feel that when you get above 300 to 500 beds that the sheer weight of operating the facility overwhelms the primary purpose, and that is delivering care to the patient.

Mr. PRINCIPI. What about the shape of the hospital?

Mr. BATEY. Well, since I am an architect by profession, obviously I have some architectural concerns when I look at the picture that was presented earlier. The shape of the facility, as I understand it, presents a significant percentage of exterior wall area because of the configuration. As we all know, the more exterior exposure you have the more expense of heating, cooling, building, et cetera, is going to exist. So, from an architect's viewpoint I would suggest that a more consolidated type of structure might be not only more economical to operate but more economical to construct.

Again, I have not looked in great detail at the design to determine how and why that design was developed.

Mr. PRINCIPI. Does HCA employ a more consolidated design plan? That is, a square or rectangle type building?

Mr. BATEY. Generally speaking, yes. Again, realizing that those facilities normally do not exceed 400 beds.

Mr. PRINCIPI. HCA does not need to take into consideration national needs when planning to build a required hospital. Your concerns are certainly more local. Does this mean that your planning process will always be more efficient than that of the VA because of the national needs or the constraints placed on the VA by its national-wide needs assessment?

Mr. BATEY. Not necessarily, sir. We go through no doubt a similar process in looking at the population demographics in developing a needs assessment, we look at the availability of medical staff, support staff, accessibility to the facility. We go through the same type of process in determining where and when and how to build a facility.

In fact, we must defend that process and that needs assessment in great detail to several level of planning agencies in order to get the certificate of need approval to build a facility. So I do not think we use any less detail in determining how and what to build. Certainly the process is shorter, obviously.

Mr. PRINCIPI. As an architect and a businessman are you opposed to a prototype design? Is a prototype design for a hospital feasible? I believe you standardize certain components of your hospitals, could you please discuss the merits of doing so and the concept of prototypes?

Mr. **Batey**. We have tried to use prototype. And by prototype I mean a standard design that is built in several different locations. We find, as has been stated here earlier today, there are local needs that need to be considered and, therefore, the same exact standard cannot be built everywhere in every situation. However, I think as I also mentioned, there are components, there are individual departments or even individual spaces that can be standard and do not have to be redesigned for every facility, whether it is an operating room, a patient room, a utility room or whatever. No matter where that is being built in what size hospital it can be at least 90 percent standard. There may be different types of instruments or equipment that would go in a particular type of operating room in a given location depending on the types of procedures that are going to be performed. But that operating room can be standard in all of its construction details.

Mr. **Principi**. Thank you very, very much.

Yes, Mr. West.

Mr. **West**. One last comment, perhaps, to clarify what Tom was just saying. He may be being a little bit modest about his way of designing hospitals. This is highly computerized in our company so that he can call up plans off the computer. A surgical operating room to do gall bladders and gastroectomies and those sorts of things is basically the same in every hospital. It is only when you get into different types of pieces of surgery that are going to be done in that room that you need a different type of an operating room.

So, if you build a hundred VA hospitals, and every time you must redesign a basic general surgery operating room, it is expensive to do that. What we do is we call up a 4-room operating room suite that is going to do certain procedures, or a 28-room one, depending on what the procedures are. We take these pieces of the puzzle and fit them together. We sit down with the physicians, and in a matter of a few days or a couple of weeks at most, we work out the differences in that particular locale. We do not go back and forth to the architects for months and years trying to work these out, because we could not afford to do that.

Now, in all fairness I think you need to know that we do not bid our projects either. There are some differences between how the Federal Government and private enterprise works. The VA must follow some rules that we do not follow. We negotiate. We use the same architects. We use the same construction firms almost exclusively because they know and we know what quality we are talking about. We know what the price is going to be. We know what the cost is going to be. They know where the doors go, and they know how to put together a very efficient hospital for us. And they know if they do not do it that way, we will not use them again. The VA cannot do that.

So if you are going to try to use some of the same concepts that the private hospitals do, some of the rules that they are required to follow must be relaxed, at least on a pilot basis, to try some of these things. It will not work as long as they are bound up by some of the controls that come from this Hill. OK?

Thank you.

Mr. PRINCIPI. Thank you very, very much, gentlemen.

[The prepared statement of Dr. O. David West, Director, Special Projects, Hospital Corporation of America, Nashville, TN, follows:]

PREPARED STATEMENT OF DR. O. DAVID WEST, DIRECTOR, SPECIAL PROJECTS, HOSPITAL CORPORATION OF AMERICA, NASHVILLE, TN

HOSPITAL CORPORATION OF AMERICA IS HONORED TO HAVE THIS OPPORTUNITY TO TESTIFY BEFORE THIS ESTEEMED BODY.

WE ARE NOT UNMINDFUL OF THE DILEMMA WHICH THIS COMMITTEE AND THE VETERAN'S ADMINISTRATION FACE AS WELL AS OUR UNITED STATES GOVERNMENT. THE DILEMMA OF HOW TO PROVIDE QUALITY, COST EFFECTIVE HEALTH CARE SERVICES, TO NOT ONLY OUR VETERANS, BUT ALL THE CITIZENS OF OUR NATION, IS A CHALLENGE THAT REQUIRES THAT THE BEST IDEAS OF GOVERNMENTAL AND NON-GOVERNMENTAL CITIZENS OF OUR COUNTRY BE EFFECTIVELY DEPLOYED.

THE REASON WE AT HCA VIEW THIS AS A NATIONAL PROBLEM RATHER THAN JUST A PROBLEM OF THE VETERAN'S ADMINISTRATION IS THAT IN 1984 10.7% OF OUR GNP WENT TO HEALTH CARE. THIS WILL CONTINUE TO INCREASE AND YET WE STILL HAVE INDIGENTS NOT GETTING ADEQUATE HEALTH CARE. WE STILL HAVE VETERANS REQUIRING ADDITIONAL HEALTH CARE SERVICES AND WE HAVE A HEALTH CARE SYSTEM THAT, ALBEIT, THE FINEST IN THE WORLD, HAS OVER CAPACITY IN CERTAIN PARTS OF THE COUNTRY AND UNDERUTILIZED CAPACITY IN OTHERS. FOR EXAMPLE, ALTHOUGH THE GEMANIC REPORT PROJECTS A SURPLUS OF 90,000 PHYSICIANS BY THE YEAR 2,000, THERE ARE STILL MANY PEOPLE IN RURAL AREAS OF THE COUNTRY THAT HAVE INADEQUATE HEALTH CARE. SIMILARLY, SEVERAL COMMUNITIES WILL PROBABLY HAVE TO CLOSE THEIR HOSPITALS BECAUSE OF UNDERUTILIZATION IN THE COMING DECADE. WE AT HCA ARE POIGNANTLY AWARE OF THE DILEMMA AND THE CHALLENGE TO OUR NATION.

I HOPE THIS IS NOT A TURN, BUT I AM REMINDED OF ONE OF THE FEW TIMES IN THE HISTORY OF OUR COUNTRY OUTSIDE OF WAR WHEN THE PRIVATE SECTOR AND PUBLIC SECTOR MELLED TOGETHER TO ADDRESS NATIONAL ISSUES.

I SPEAK OF THE CHALLENGE THAT THE YOUNG PRESIDENT JOHN F. KENNEDY GAVE TO THE NATION OF PUTTING A MAN ON THE MOON BY THE 1970s, AND THE FACT THAT OUR SPACE AGENCY, THE NATIONAL AERONAUTICS AND SPACE ADMINISTRATION, WHILE RELATIVELY SMALL IN SIZE, SOME 27,000 EMPLOYEES MARSHALLED THE RESOURCES OF THE PRIVATE SECTOR, THE AEROSPACE INDUSTRY AND SOME 365,000 PEOPLE AND OVERCAME, WHAT APPEARED TO BE, INSURMOUNTABLE TECHNICAL DIFFICULTIES AND WE PUT A MAN ON THE MOON.

THE CHALLENGE, IT SEEMS TO US AT HCA, IS HOW DO WE, IN THE PRIVATE SECTOR, ALBEIT, A TAX PAYING COMPANY, BUT A TAX-PAYING COMPANY DEDICATED TO QUALITY HEALTH CARE, HELP ADDRESS THIS EMERGING NATIONAL ISSUE IF NOT, NATIONAL CRISIS. WE CAN'T DO IT ALONE. AND WE INTUITIVELY SENSE THAT THE VETERAN'S ADMINISTRATION, NOR THE DEPARTMENT OF DEFENSE, NOR THE U.S. GOVERNMENT, CAN DO THIS ALONE. ALL OF US IN THIS COUNTRY, STATE AND LOCAL GOVERNMENTS, NATIONAL GOVERNMENTS, MEMBERS OF THE GENERAL ASSEMBLY, AND STATES, THE CONGRESS, THE FEDERAL AGENCIES, THE NOT-FOR-PROFIT HOSPITALS, TAX PAYING HOSPITALS, THE PHYSICIANS, THE SPECIALISTS, ALL ARE GOING TO HAVE TO WORK TOGETHER TO SOLVE THIS EMERGING HEALTH CARE CRISIS. AND THIS IS ALL WE HAVE BEEN PROPOSING AT HCA, THAT WE WANT TO BE A PART OF THE SOLUTION, NOT A PART OF THE PROBLEM.

IN SEVENTEEN SHORT YEARS, HCA HAS GROWN TO ONE OF THE LARGEST HEALTH CARE COMPANIES IN THE WORLD. WE OWN OR MANAGE OVER 400 HOSPITALS, OVER 60,000 BEDS, ARE LOCATED IN CLOSE PROXIMITY TO NAVAL, ARMY, AND AIR FORCE BASES, AS WELL AS VETERAN'S HOSPITALS. IT SEEMS TO US WHAT WE JOINTLY DID IN THE 70's TO MOVE OUR NATION FORWARD AND ADVANCE ITS SPACE TECHNOLOGY CAN BE REPLICATED INTO THE 80's AND 90's IN HEALTH CARE, AND THAT THE VETERAN'S ADMINISTRATION IS UNIQUELY POSITIONED TO PROVIDE LEADERSHIP IN THIS TO ADVOCATE THE CONCEPT.

WHAT CAN WE, IN THE PRIVATE SECTOR, NOT ONLY HCA BUT OTHER HEALTH CARE PROVIDERS DO, TO ADDRESS THE CHALLENGES AND PROBLEMS THAT THE VETERAN'S ADMINISTRATION FACES IN ATTEMPTING TO DELIVER QUALITY HEALTH CARE SERVICES TO OUR NATION'S VETERANS. IN AN ENVIRONMENT WITH SHRINKING FINANCIAL RESOURCES AVAILABLE FROM THE FEDERAL GOVERNMENT AND AN ENVIRONMENT WHEREIN THE REGULATIONS AND PROCEDURES THAT HAVE BUILT UP THROUGH THE YEARS IN THE VA BUREAUCRACY, AND I MUST SAY BASED ON LAWS AND DIRECTIVES THAT FREQUENTLY COME DOWN FROM THE HILL, WHEREIN THE RESULTING PROCESSES ARE SO COMPLEX AND BURDENSOME THAT A HOSPITAL THAT IS NEEDED TODAY MAY NOT BE BUILT FOR ANOTHER 8 TO 10 YEARS AND EVEN WHEN IT IS BUILT THE COST FAR EXCEEDS THE ORIGINAL ESTIMATES PRIMARILY BECAUSE OF DELAYS INVOLVED IN WORKING THE PROCESS THROUGH.

WE FACE SOME OF THE SAME PROBLEMS IN THE PRIVATE SECTOR, BUT GIVEN THE COST OF MONEY WE MUST MOVE QUICKLY, WE MUST MOVE EFFICIENTLY, AND WE MUST MOVE EFFECTIVELY. SO WHAT WE BASICALLY DO, THEN, IS TO TRY TO MOVE A CONCEPT OUT INTO THE MARKETPLACE AS QUICKLY AS POSSIBLE. IF WE DIDN'T WE COULDN'T GROW, IF WE DIDN'T WE COULD NOT BE PROFITABLE. AND IT SEEMS TO US THERE MAY BE SOME WAY THAT WE COULD USE THIS MANAGERIAL KNOW-HOW, THE TECHNICAL EXPERTISE WE HAVE, AND OUR HUGE HOSPITAL FRANCHISE, WHICH IRONICALLY MANY OF THE MILITARY FACILITIES ARE USING AS A WAY TO MEET THE NEEDS OF VETERANS AND PERHAPS THE NEEDS OF MILITARY PERSONNEL, IN SOME SMALL WAY, THROUGH JOINT VENTURES AND COOPERATIVE ARRANGEMENTS, SO THAT LIKE THE SPACE INDUSTRY OF THE 70'S THE HEALTH CARE INDUSTRY COMBINES WITH GOVERNMENT IN A PARTNERSHIP TO RENDER COST EFFECTIVE AND QUALITY HEALTH CARE SERVICES.

WE COME HERE TODAY, NOT TO TESTIFY WITH SOLUTIONS, NOT TO PROVIDE INSTANT FIXES, BUT TO POINT OUT WE HAVE A PROVEN CAPACITY AND WE WANT TO AVAIL IT TO THE VETERAN'S ADMINISTRATION, TO THIS COMMITTEE, TO ANY ONE WHO, LIKE WE, SEEKS TO SOLVE THESE PROBLEMS OUR NATION FACES. WE WANT YOU TO THINK OF HOSPITAL CORPORATION OF AMERICA AS PART OF THE SOLUTION, NOT PART OF THE PROBLEM.

WHEN WE TALK ABOUT THE HOUSTON SITUATION, WE DO IT MERELY FROM A FACTUAL PRESENTATION STANDPOINT. WE DO NOT WANT TO APPEAR SELF-SERVING, NOR DO WE WANT TO APPEAR ADVOCATING A CERTAIN POSTURE, BUT RATHER HERE ARE THE FACTS AS WE SEE THEM IN THAT LOCALE. AND ALL IT POINTS OUT IS THE NEED FOR COOPERATIVE ARRANGEMENTS, COOPERATIVE PLANNING, SEEKING INNOVATIVE SOLUTIONS TO PROBLEMS THAT HAVE BEEN WITH OUR COUNTRY FOR THE PAST DECADE OR TWO. THEY ARE NOW SURFACING THE NATIONAL LEVEL.

YES, IT APPEARS AS THOUGH SOME VA HOSPITAL BEDS COST TWICE AS MUCH AS THOSE BUILT IN THE PRIVATE SECTOR AND MORE TO OPERATE WHEN YOU CONSIDER THE LONG LENGTH OF STAY AND TYPE OF CARE THAT IS GIVEN. SOME VA NURSING HOME BEDS COST FIVE TIMES AS MUCH TO BUILD AND TWICE AS MUCH TO OPERATE AS THE PRIVATE SECTOR. ON THE ONE HAND, IT IS NOT SURPRISING, GIVEN THE CUMBERSOME, BUREAUCRATIC PROCESSES THAT THE CAREERISTS AND DEDICATED PEOPLE AT THE VA MUST FOLLOW. ON THE OTHER HAND, THE REAL ISSUE IT SEEMS TO US IS WHETHER THERE ARE BETTER WAYS OF SATISFYING THE NEEDS OF THE VETERANS THROUGH EXPANDED COOPERATIVE ARRANGEMENTS.

ACCORDING TO THE HOUSTON HOSPITAL COUNCIL, THE GENERAL HOSPITAL CENSUS IN HOUSTON HAS EXPERIENCED A PRECIPITOUS DROP IN THE LAST TWO YEARS TO A JANUARY 1985 LEVEL OF 56.78%. THIS LEAVES 167,733 BEDS A MONTH EMPTY OR 5410 BEDS PER DAY. THIS WOULD EQUAL A 6760 BED HOSPITAL AT AN OPTIMAL OCCUPANCY LEVEL OF 80%. THIS DECLINE IS BECAUSE OF

DRAMATIC DECLINES IN USE RATE (APPROXIMATELY 1110 PATIENT DAYS PER 1000 IN 1982 - 870 PATIENT DAYS PER 1000 IN 1984).

CHANGES IN THE DELIVERY AND MEDICINE THAT ENCOURAGE OUTPATIENT SURGERY AND TREATMENT.

THE IMPACT OF DRGS AND THE ENTRY OF COMPETITION INTO THE MARKETPLACE.

THE ABOVE EXAMPLE IS REPEATED THROUGHOUT THE COUNTRY, AND I PREDICT THE DECLINE IN INPATIENT HOSPITAL USE WILL CONTINUE AND THAT WE WILL EXPERIENCE EVEN LOWER OCCUPANCY LEVELS FOR THE NEXT TWO TO THREE YEARS.

NOW, SPEAKING FROM A NON-GOVERNMENTAL POSITION, THE THOUSANDS OF NON-GOVERNMENTAL HOSPITALS HAVE EXCESS CAPACITY, AND THAT CAPACITY IS GROWING. THAT FACT REQUIRES ME, AS A BUSINESS MAN AND A CITIZEN, TO ASK TWO SIGNIFICANT QUESTIONS. DOES IT MAKE SENSE TO CONTINUE TO BUILD MORE BEDS IN OUR SYSTEM WHEN THERE ARE MORE THAN AN ADEQUATE NUMBER OF QUALITY BEDS AVAILABLE LOCALLY IN A PARALLEL SYSTEM? ARE WE NOT ALL TRYING TO ACCOMPLISH THE SAME TASKS, TO PROVIDE COST EFFECTIVE, QUALITY HEALTH CARE FOR AMERICANS?

THERE IS A DEFINITE NEED AND A ROLE FOR THE VA IN OUR HEALTH CARE CULTURE. THE VA PROVIDES HEALTH CARE FOR 12-15% OF THE VETERANS IN THIS COUNTRY. THERE IS ALSO A ROLE FOR THE NON-VA HOSPITALS WHO PROVIDE HEALTH CARE FOR 85-88% OF THE VETERANS. LET'S TEAM UP TOGETHER AND RESOLVE THE PROBLEMS, AND LET'S PROVIDE THE VERY BEST OF BOTH SYSTEMS TO THE VETERAN, QUALITY, COST EFFECTIVENESS, CONVENIENCE, ETC.

AT THIS POINT I WOULD LIKE TO ASK MY COLLEAGUE, TOM BATEY, ETC.

Mr. Principi. Thank you very much.

The hearing is adjourned. Thank you.

[Whereupon, at 12:20 p.m., the committee was adjourned.]

APPENDIX

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans Administration

MAR 20 198[illegible]

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman: Frank

I am writing to update you on the progress of the Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities. As you know, the consulting firms of Booz, Allen and Hamilton Inc. and RTKL Associates Inc. are conducting this study. The study is designed to provide information and recommendations to us which we can use to ensure that our internal organizational structures and procedures for carrying out our medical facilities' construction program are as efficient and effective as possible.

Based on the recommendations of the Chief Medical Director; the Associate Deputy Administrator for Logistics; the Director, Office of Construction; and other Agency staff, we have expanded the tasks in the work statement for the study. These tasks are within the scope of the original work statement and include: (1) on-site data collection at 17 VA medical centers and 9 general contractors and architect/engineering firms, (2) an expanded analysis of the minor construction program, (3) an increasing Agency review period following submission of each draft deliverable, and (4) a separate, stand-alone assessment of the strengths and weaknesses of the delegated versus non-delegated Nursing Home Care Unit design and construction projects.

These added tasks have changed the study's completion date from January 21, 1985, to April 8, 1985, and have increased the cost of the study from $546,593 to $926,910. While the increase in the cost of the study is significant, I believe the additional analyses by the contractor will improve the depth and breadth of the study to make it more comprehensive than originally planned.

After we have had the opportunity to review the contractors' completed study, I will be pleased to brief you on the study's findings and recommendations. Thank you for your continuing interest in our health care facility design and construction program.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN
ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
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JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

May 6, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry:

I am writing in follow-up to certain issues discussed during the Senate Veterans' Affairs Committee March 26 and 27, 1985, hearing on VA medical facility construction.

As Chairman, I believe the hearing provided an opportunity for the Committee to pursue certain specific areas of concern relating to the VA's construction planning process. As you know, I believe that the future direction of the VA's construction program must be examined in the context of an anticipated increased demand for services by the aging veteran population, certain policy changes proposed by the Administration pertaining to eligibility for VA medical care, and the limited availability of health care resources. VA construction program planning should, therefore, integrate certain considerations into the construction process. I urge the VA to consider the following:

First, prior to the replacement and modernization of existing facilities or the construction of new facilities, the VA should assess the feasibility of leasing or purchasing already existing private sector beds or facilities.

Second, as directed by the Committee in its views accompanying the May 24, 1984 construction resolution, the VA should modify its criteria and process for sizing VA hospitals. It is my view that in determining the size of new or replacement facilities, the VA should take into account the following factors: the percentage of service-connected veterans to be served; the availability of already existing or planned community beds; the impact of diagnostic-related groups (DRG's) on the length of stay of VA patients; and the need for and use of non-institutional forms of care.

Third, the VA should re-examine its entire construction planning process in order to reduce the time involved in the planning, design, and construction of VA medical facilities. A special effort should be made to standardize the design and components of both acute care and long-term care facilities.

I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

1. Specific information substantiating the VA's view that medical care provided by the VA is more cost-effective than medical care provided by private sector facilities;
2. A summary of existing medical programs, as documented by current MEDIPP data, for each VA medical facility and medical district and a summary of a plan for the projected medical and construction needs for each of the facilities and districts for the next 10 years taking into consideration changing needs of veterans; and
3. Criteria or standards setting forth guidelines, including those pertaining to occupancy rates, for closing entire facilities or individual programs.

With respect to requests made on March 27:

1. A copy of the results of the study by Booz Allen and the VA's plans for the implementation of Booz Allen's recommendations;
2. A list of facilities available for lease or purchase in areas where the VA has already identified a need for a new or replacement facility;
3. A list of ongoing litigation involving disputes with private contractors, change orders, architectural issues, and others;
4. Documentation relating to the need for or lack of need for VA hospital beds in the Florida panhandle/Mobile, Alabama area; and
5. Information on the percentage of veterans receiving medical care in private sector facilities and information documenting the differences in characteristics and needs of these veterans as compared to those veterans receiving care in VA facilities. Please provide a projection of any shift in care for these veterans as well as your views as to the percentage of the veteran population for which the VA should provide care.

In a related matter, as discussed at the hearing, I would urge you to engage in an open dialogue with private health care organizations, such as the Hospital Corporation of America and the American Health Care Association, for the purposes of exchanging information about VA and private sector practices relating to the planning, design, and construction of medical facilities and to work cooperatively with such organizations to attempt, on a pilot program basis, to identify cost containment and sharing innovations which would improve the efficiency and reduce the time and costs of the VA's construction planning process.

Thank you for your cooperation. I look forward to your response.

Sincerely,

Frank H. Murkowski
Chairman

Veterans
Administration

JUN 5 1985

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to provide you with the Agency's responses to the questions you, Senator Stafford and Senator Denton forwarded following the Committee's March 26 and 27, 1985, hearing on VA medical facility construction.

I appreciate this opportunity to provide additional information for the record.

Sincerely yours,

DONALD L. IVERS
General Counsel

Enclosure

In Reply Refer To

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question: 1. Specific information substantiating the VA's view that medical care provided by the VA is more cost-effective than medical care provided by private sector facilities:

Answer: The Allocation Development Service is currently preparing analyses comparing the cost of medical care in the VA system with costs in non-VA facilities. Comparisons will be based on information from the Health Care Financing Administration and from selected states and localities able to provide adequate data bases. Preliminary investigations suggest that, given its mandate to provide high-quality care to poorer and sicker patients, VA costs are comparable to those in the private sector.

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

2. A summary of existing medical programs, as documented by current MEDIPP data, for each VA medical facility and medical district and a summary of a plan for the projected medical and construction needs for each of the facilities and districts for the next ten years taking into consideration changing needs of veterans;

Answer: The VA, through the MEDIPP process, has estimated the needs of VA medical facilities into the future. These estimates of need have been coordinated with the VA construction planning process. Accordingly, two packages of data are provided.

First, there is included a listing based on the 1984 MEDIPP submissions which shows the actual number of VA beds and outpatient visits as of the end of Fiscal Year 1983 and the projected need for the year 1995. This listing shows data by VA medical district and by VA medical center. The results of the 1984 MEDIPP submission are in the final stages of review, so the data in this package are still subject to revision; however, it is anticipated that at this stage of the review, any changes would be minimal and not likely to affect any of the facility totals significantly.

Second, there is included a copy of the "FY 1985 - 1989 Five Year Medical Facility Construction Needs Assessment." The data in this document have been coordinated with the data from the previously approved 1983 MEDIPP submissions. This document, which is an annual submission to Congress, is currently being revised. A new "assessment" is due to Congress on June 30, 1985. The data in the new "assessment" are being coordinated with the data from the 1984 MEDIPP submissions.

Attachments (Retained in committee files.)

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

3. Criteria or standards setting forth guidelines, including those pertaining to occupancy rates, for closing entire facilities or individual programs.

Answer: The VA is giving special planning emphasis to development of actions which will enable the Agency to provide needed services within available resources. The MEDIPP guidance requires VA's medical districts to give priority attention to such actions, by conducting rigorous reassessments of district and facility missions, with a view to increasing the cost-effectiveness of services. Specifically, the districts are encouraged especially to consider actions which would:

- consolidate facilities;
- increase sharing and/or contracting with cost-efficient community and other resources, where to do so would be consistent with VA quality requirements;

- eliminate less essential bed services;
- increase use of ambulatory care and other alternatives to inpatient services; and
- otherwise increase efficiency and productivity.

These efforts are intended to assure that the VA will organize and allocate its facilities and other resources in a way which will provide the best possible services to the aging veteran population over the coming years. In some cases, the termination of individual facilities or programs may be necessary to make resources available for higher priorities. Any such decisions must consider a wide variety of factors, not only current occupancy rates, workloads, and costs. They must also address demographic projections, future workloads, and various options for achieving the optimum mix, location, size and quality of services.

Given the number of variables which must be considered in each instance, the VA does not use a single set of criteria for closing facilities or programs. Instead, the VA is in the process of developing a series of specific indicators to flag programs and facilities where opportunities may exist to improve the balance of services and workloads, considering the full range of options available. These indicators are expected to be used by all levels in the Department of Medicine and Surgery to identify and evaluate opportunities and recommendations for such improvements during the planning process.

Indicators under staff consideration at this stage relate to occupancy rates, demographic and workload projections, costs per unit of workload, case mix trends, facility condition, and the geographical distribution of programs. When the list of indicators is approved, we would expect the districts to propose an appropriate mission or operating change for each facility or program which exhibits a significant number of indicators, or else to present convincing justification as to why no such change is needed. These indicators will be an important factor in Regional and Central Office reviews of district plans.

When the list of program review indicators is completed by late summer, we will be glad to share them with the Committee.

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 27, please submit the following information:

1. A copy of the results of the study by Booz Allen and the VA's plans for the implementation of Booz Allen's recommendations.

Answer: The Administrator's policy is to transmit the report after he has had an opportunity to study it thoroughly and to make his decision on the recommendations he will implement. The Administrator requested and received a briefing on the study's findings on the day the study was completed. Department and staff offices are now reviewing the report and we anticipate a decision soon from the Administrator. Thereafter, a plan for implementing the recommendations will be developed. We shall then provide you with a copy of the Booz Allen study and the plan for implementation and/or brief you at that time.

Question: 2. A list of facilities available for lease or purchase in areas where the VA has already identified a need for a new or replacement facility.

Answer: The VA does not presently have a list of facilities which are available for lease or purchase in areas where we have identified a need for a new or replacement facility. In those areas where we are actively proceeding with the development of plans for new or replacement facilities, we are not aware of the availability of any existing facilities which could suit our needs. In the case of Palm Beach County, Florida, a private hospital did tentatively offer land and development of shared services, however, the facility has since indicated no further interest. No offers to lease or purchase private facilities were received for Brevard County, Florida.

I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 27, please submit the following information:

> 3. A list of ongoing litigation involving disputes with private contractors, change orders, architectural issues, and others;

Answer:

See the attached Quarterly Report of the Board of Contract Appeals and the Contract Appeals Board dated April 12, 1985.

Attachment

Veterans
Administration

Memorandum

Date April 12, 1985

To Deputy Administrator (001)

From Board of Contract Appeals (09)

Subj Quarterly Report of Board of
Contract Appeals (BCA) and
Contract Appeals Board (CAB)

1. Caseload summary for the quarter ending March 31, 1985:

(a) Appeals pending at beginning of quarter	260
(b) New cases docketed	58
(c) Appeals reinstated	3
(d) Cases disposed of (listed separately by docket number beginning on p. 50)	39
(e) Appeals pending at end of quarter	282

2. Distribution of pending appeals:

Contract Type	Station Level		Central Office		Total	Percentage of Pending Appeals
Construction	189	+	64	=	253	90%
Supply	7	+	1	=	8	3%
Service	20	+	1	=	21	7%
Total	216	+	66	=	282	100%

3. Attached is pertinent data (including the status) of each case on the BCA/CAB docket as of March 31, 1985 (Section I), and of each case disposed of during the quarter (Section II).

JOHN J. CORCORAN
Chairman

Att:

Attachments (Retained in committee files.)

VA FORM 2105
MAY 1983
U.S. GOVERNMENT PRINTING OFFICE: 1984-421-388 [illegible]

BEST COPY AVAILABLE

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

4. Documentation relating to the need for or lack of need for VA hospital beds in the Florida panbhandle/Mobile, Alabama area;

Answer: The issue of the need for or lack of need for a VA hospital in Mobile, Alabama or the Florida panhandle has been extensively analyzed and reviewed. The attached papers contain the documentation which supports the decision of the Veterans Administration to place a VA hospital in the Florida panhandle in Okaloosa County (Attachment).

(Retained in committee files.)

QUESTION

5. Information on the percentage of veterans receiving medical care in private sector facilities and information documenting the differences in characteristics and needs of these veterans as compared to those veterans receiving care in VA facilities. Please provide a projection of any shift in care for these veterans as well as your views as to the percentage of the veteran population for which the VA should provide care.

ANSWER

Two sources of data are particularly relevant in estimating the percentage of veterans receiving care in VA facilities versus the percentage receiving care in Non-VA facilities and in describing differences between these two populations. These are the 1979 National Survey of Veterans and the Health Interview Survey conducted at regular intervals by the National Center for Health Statistics. These Sources point out that approximately 12% of veteran discharges are from VA facilities. They also point out that veterans receiving care at VA facilities tend to be older, have lower incomes, and suffer from certain conditions to a greater degree than veterans receiving care in Non-VA hospitals. The surveys indicate that a higher percentage of veterans receiving care at VA facilities are in the 45-54 and 55-64 age groups, for example. Also, nearly 60% of those seen at VA medical centers had low family incomes (under $10,000) compared to less than 20% of those discharged from Non-VA hospitals. Although care at VA facilities accounted for only 12% of total veteran discharges, VA care for mental and personality disorders accounted for 29% of veteran discharges in this are; VA care for malignant neoplasms (cancer) accounted for 18% of all veteran discharges for this condition; and VA care for chronic respiratory conditions accounted for 17% of veteran discharges during the period of the surveys. In summary, veterans receiving care at VA facilities are concentrated in older age groups, are poorer, and suffer from more chronic conditions than veterans receiving care in private sector hospitals.

The planning process the Department of Medicine and Surgery uses does not project any shift in care from what is presently provided. A four-year historical trend is projected forward to the 1990-2000 planning horizon with adjustments made for the increased aging of the veteran population. The percentage of eligible veterans that find health care attractive from the VA may be effected by a number of external influences, one of those being changes in Medicare eligibility or co-payment. The VA cannot either control nor project such changes, therefore, planning for the future must be based on historical trends.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 25 198

Honorable Frank H. Murkowski
Chairman,
Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Mr. ~~Chairman~~: Frank

I am pleased to reply to your letter of May 6, 1985, concerning issues discussed during the Senate Veterans' Affairs Committee hearings of March 26 and 27, 1985. This is a final response and contains information on three questions not already answered.

We agree with your view that prior to replacement or modernization of existing facilities or the construction of new facilities, the Veterans Administration should explore the feasibility of leasing or purchasing already existing private sector beds or facilities. It is our experience, however, that seldom do facilities exist in the private sector which can adequately provide for the needs of the VA without substantial modernization. Most often, community hospital facilities which are available are being abandoned because they have outlived their usefulness to provide health care as a result of age or physical deterioration. In regard to nursing homes, our studies of leasing nursing homes have indicated that it is much more cost effective to the government to construct as opposed to leasing nursing home facilities. In our future planning we will continue to give consideration to available community facilities whose acquisition might obviate the need for VA construction.

The sizing of future replacement/modernization projects will be based on a model that was developed, at the direction of Congress, by a group from the VA and GAO. It is a well thought-out model that considers not only VA historical experience, but also community factors such as length of stay. The implementation of a bed-sizing model, such as the one developed by the Committee, should only be considered after broad public discussion and participation.

I agree completely that we should reexamine our construction planning process, and for that reason we retained the services of the Booz-Allen Hamilton/RTKL Consulting Joint Venture to fully examine our construction processes. The Booz-Allen Hamilton/RTKL Report has recently been received by the Agency and is currently undergoing review. I am confident that this report and our own review will result in changes which can improve our construction program.

Your interest in this matter is appreciated.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

COMPREHENSIVE STUDY OF THE VA's ORGANIZATION AND PROCEDURES FOR CONSTRUCTING HEALTH CARE FACILITIES. -- EXECUTIVE SUMMARY. BOOZ, ALLEN & HAMILTON INC.

This executive summary provides an overview of three reports to the Veterans Administration (VA) that document, evaluate, and recommend improvements to the Health Care Facility (HCF) Construction Process. It is the final report in the Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities.

1. THE PURPOSE OF THIS STUDY IS TO EVALUATE AND RECOMMEND IMPROVEMENTS TO THE VA's HCF CONSTRUCTION PROCESS

The purpose of the study is to assess the organization and procedures used by the VA to construct health care facilities. It was initiated as a result of several factors, probably the most important of which was the VA's recognition that the need for new facilities is increasing and will continue to increase with the greying of the veteran population and the aging of the current HCF inventory. Because the HCF Construction Process is critical to meeting this need and, hence, to the ability of the VA to carry out its mission, the VA felt that a study of the efficiency and effectiveness of the process was necessary.

A second purpose of the study is to look at criticisms that have been aimed at the process itself. Increases in construction activity have already begun to strain available construction resources. As a result, the current process has been criticized both from within and outside the VA for being costly, lengthy, and inflexible. The VA felt that a study was needed to determine the underlying causes of these criticisms and to develop alternatives for resolving them.

Booz, Allen & Hamilton Inc. and RTKL Associates Inc. conducted the overall study of the HCF Construction Process to address these objectives. As stated by the VA, the study has three goals:

- To determine, consistent with the health care mission of the VA, the most effective and efficient internal organizational and procedural structures for defining, developing, designing, constructing, maintaining, and improving medical and health care related capital facilities of high quality, consistent with resource and timeliness considerations
- To assist the VA in evaluating the appropriateness, effectiveness, and efficiency of its current organizational and procedural structures for the functions described above
- To implement, if appropriate, innovative, practical alternatives to the VA's current organization and procedures for delivering HCF construction programs by means of fully supported recommendations for change.

The study has been carried out in three phases, with a study report developed at the completion of each phase:

- Phase I, Process Documentation - Presented detailed data gathered through interviews and a review of existing documents; described the organization, information and communication flows, program planning linkages, and process controls of the HCF Construction Process
- Phase II, Data Evaluation and Analysis - Presented the results of 11 process analyses and 24 summary problem statements defining weaknesses in the HCF Construction Process
- Phase III, Proposals and Recommendations - Presented recommendations for improving construction policies and procedures and the organization for carrying out the HCF Construction Process.

This executive summary provides an overview of the previous study reports and is the Phase IV Final Report.

2. THE DEPARTMENT OF MEDICINE AND SURGERY (DM&S) AND THE OFFICE OF CONSTRUCTION (O/C) SHARE RESPONSIBILITY FOR PLANNING, DESIGNING, AND CONSTRUCTING HEALTH CARE FACILITIES

The purpose of the HCF Construction Process is to translate defined health care facility construction needs into in-place construction. It requires a significant level of funding, close to $750 million in FY84, and the efforts of staff in four major organizations in the VA: the Office of the Administrator; DM&S, O/C and VA Medical Centers (VAMC).

Construction needs are addressed in the HCF Construction Process through the planning and execution of construction projects. Procedures used and responsibilities assigned depend on the type of construction project or need addressed. The four types of construction projects are as follows:

- Major Construction - Projects with an estimated cost of $2 million or more
- Minor Construction - Projects with an estimated cost of between $400,000 and $2 million
- Minor Miscellaneous Construction - Projects with an estimated cost of between $100,000 and $400,000
- Nonrecurring Repair and Maintenance (NRM) - Projects for nonrecurring maintenance work or repair, replacement of or additions to building service equipment, and/or minor improvements where the minor improvement portion of the project is between $15,000 and $100,000.

This section briefly describes procedures and responsibilities for carrying out these projects, as documented in Phase I of the study.

(1) Policies and Procedures Followed in the HCF Construction Process Directly or Indirectly Support Project Planning, Design, and Construction Activities

Most activities of the HCF Construction Process focus on the management and execution of three construction project phases:

- Project planning - During which design requirements are developed for identified construction needs
- Design - During which project plans are translated into construction documents
- Construction - During which construction documents are executed to produce in-place construction.

Project planning, although performed for all types of construction, is a formal process phase only for Major and Minor Construction projects. Project planning is generally a two-step process. The initial step, development of a data package, requires the collection of VAMC workload and staffing projections. This information is then used to carry out the second step, development of a space program. The space program, developed by applying data package projections to space planning criteria, provides information required to define project design requirements.

Project design generally consists of three distinct activities:

- During concept development, the project scope is generally defined and a conceptual approach to design is selected
- During preliminary plans development, architectural, site, and engineering plans are prepared to define the design solution
- During working drawings development, a complete graphic and narrative representation of the project is prepared.

Design activities result in a set of construction documents of sufficient detail to permit execution of the project in precise form, size, and materials.

The final phase--construction--consists of the "brick and mortar" activities required to execute design documents. During this phase, detailed shop drawings and material submissions are developed and approved and actual construction takes place.

Other support activities are required to manage and execute these phases of the process. Some of those activities, such as standards development and procurement and contracting, directly support execution of HCF Construction Process activities. Others, such as program budgeting and development of managment information, support the management of the HCF Construction Process.

Exhibit 1 illustrates the current process, showing relationships among activities and average execution time required. The duration of the phases varies by project type. For activities beginning with project planning and ending with design, for example, the process requires an average of 2 years for small NRM projects and 8 years for Major Construction projects.

(2) Responsibilities for Managing and Executing the HCF Construction Process Are Assigned to Four Major Organizations in the VA

The completion of construction projects through the HCF Construction Process requires the accomplishment of four process functions:

- Planning, which includes responsibility for identifying and defining construction program and project requirements
- Control, which includes responsibility for monitoring and evaluating project and process performance
- Execution, which includes responsibility for designing and constructing facilities
- Support, which includes responsibility for standards, procurement and contracting, management information, and other functions required to carry out the HCF Construction Process.

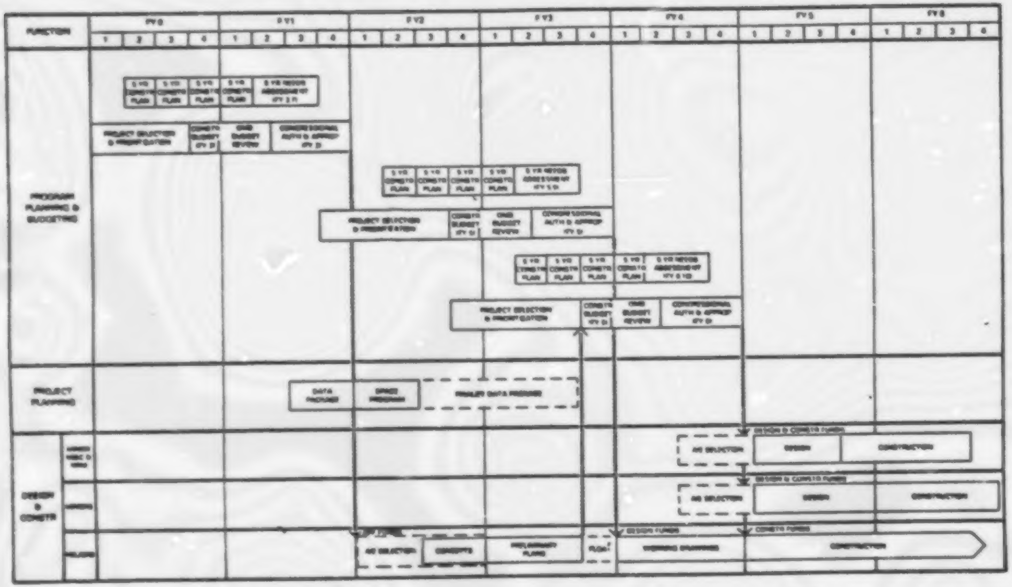
These responsibilities are assigned to four organizations in the VA: Office of the Administrator, O/C, DM&S Central Office, and VAMCs.

The Office of the Administrator is responsible for process oversight--one type of process control. Within this office, General Counsel is responsible for legal oversight and is involved generally in review of contract documents and claims. The Controller's Office is responsible for budget and fiscal oversight and is involved in all phases of the process. The Office of Program Planning and Evaluation is generally involved in the construction process during overall agency program planning and budgeting activities.

The Office of Construction (O/C) is involved in all phases of the construction process, and has a role in both management and execution. This office is responsible for:

- Developing program and project plans
- Developing concepts for Major Construction projects and preliminary plans and working drawings for a small number of Major and Minor Construction projects
- Performing project and process control responsibilities for Major and Minor Construction

EXHIBIT I
OVERVIEW OF CURRENT HCF CONSTRUCTION PROCESS


FUNCTION
FY 0
FY 1
FY 2
FY 3
FY 4
FY 5
FY 6
1
2
3
4
PROGRAM PLANNING & BUDGETING
5 YR CONSTR PLAN
5 YR NEEDS ASSESSMENT
PROJECT SELECTION & PRIORITIZATION
CONSTR BUDGET
OMB BUDGET REVIEW
CONGRESSIONAL AUTH & APPROP
PROJECT PLANNING
DATA PACKAGE
SPACE PROGRAM
FINALIZE DATA PACKAGE
DESIGN & CONSTR
DESIGN & CONSTR FUNDS
A/E SELECTION
DESIGN
CONSTRUCTION
DESIGN FUNDS
CONCEPTS
PRELIMINARY PLANS
FLOAT
WORKING DRAWINGS
CONSTR FUNDS

1 ASSUMES USE OF DESIGN FUND FOR MAJOR CONSTRUCTION PROJECTS

2 "FLOAT" INDICATES SLACK TIME AVAILABLE TO COMPLETE PRELIMINARY PLANS BEYOND THE AMOUNT OF TIME TYPICALLY PLANNED BEFORE WORKING DRAWINGS ARE DELAYED.

- Developing standards and management information and procuring and contracting
- Executing on site construction projects.

During FY84, approximately 750 full-time equivalent (FTE) personnel in O/C were devoted to these functions.

Compared with this level of effort, the DM&S Central Office--specifically, the Office of Engineering, Planning, and Construction (FEPAC), plays a smaller role in the HCF Construction Process. Within FEPAC, staff are responsible for program and project planning and process control for all types of construction projects. During FY84, approximately 75 FTEs in FEPAC were devoted to these functions.

The fourth major organization involved in the HCF Construction Process is the DM&S field organization, specifically VAMCs. Much of the VAMC effort in the process is involved in managing and, in some cases, executing Minor Construction and NRM projects. VAMCs have also been increasingly assigned project management responsibility for Major Construction projects. Together with responsibilities for construction planning (e.g., development of 5-Year Facility Construction Plans and data packages), these functions required approximately 800 FTEs during FY84.

Exhibit 2 illustrates key responsibilities and relationships of elements in these four organizations.

3. ANALYSES OF THE HCF CONSTRUCTION PROCESS REVEALED PROBLEMS IN INTEGRATION OF THE CONSTRUCTION AND MEDICAL CARE PROGRAMS

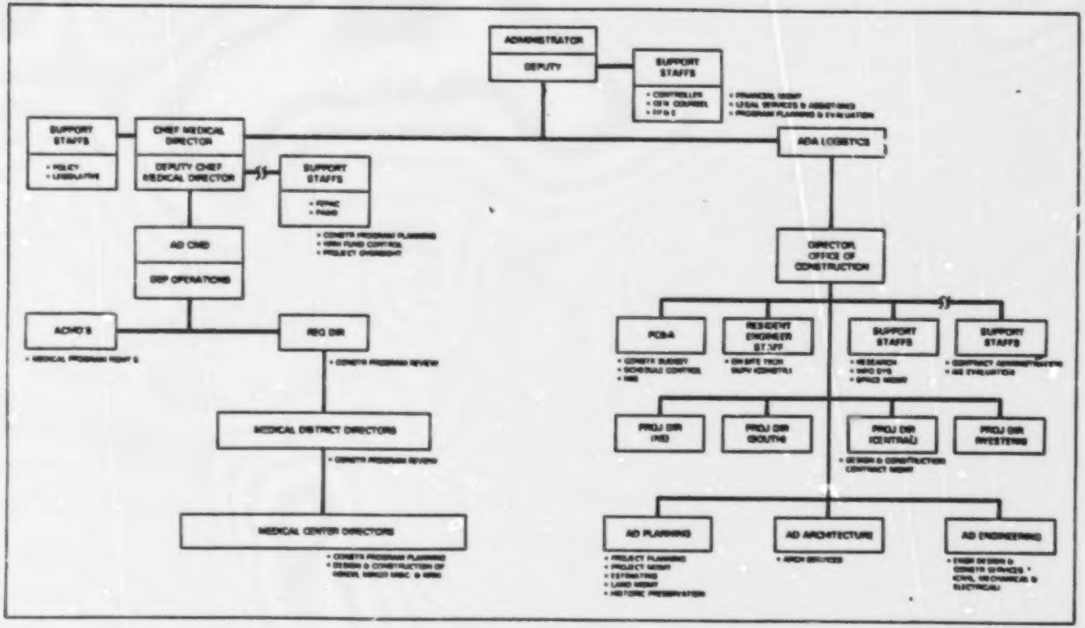
Detailed analyses were conducted during Phase II of this study to identify areas where improvements could be made in the HCF Construction Process. The analyses identified weaknesses in policies, procedures, and organizational responsibilities that result in poor coordination between the construction and medical care programs. Program coordination requirements and problems are described below.

(1) Health Care Program and Health Care Resource Management Must Be Highly Integrated for the VA To Accomplish Its Mission

The effective use of resources in delivering health care services is a key determinant of overall VA effectiveness. While effective management of staff resources is perhaps most critical, effective management of facilities, equipment, and supplies is also of major importance. Planning for these resources, execution of the plans, and control over the use of resources are required for the effective delivery of health care services.

Effective coordination or integration between program management and resource management is essential in carrying out any program, but it is critical to effective health care delivery within the VA. Its importance can be attributed to three factors:

EXHIBIT 2
CURRENT CONSTRUCTION PROCESS ORGANIZATIONAL STRUCTURE


ADMINISTRATOR
DEPUTY
SUPPORT STAFFS
• CONTROLLER
• GEN COUNSEL
• PP & E
• FINANCIAL MGMT
• LEGAL SERVICES & ASSISTANCE
• PROGRAM PLANNING & EVALUATION
SUPPORT STAFFS
• POLICY
• LEGISLATIVE
CHIEF MEDICAL DIRECTOR
DEPUTY CHIEF MEDICAL DIRECTOR
SUPPORT STAFFS
• CONST'N PROGRAM PLANNING
• MRM FUND CONTROL
• PROJECT OVERSIGHT
AD CMD
DEP OPERATIONS
ACMD'S
• MEDICAL PROGRAM MGMT
REG DIR
• CONST'N PROGRAM REVIEW
MEDICAL DISTRICT DIRECTORS
• CONST'N PROGRAM REVIEW
MEDICAL CENTER DIRECTORS
• CONST'N PROGRAM PLANNING
• DESIGN & CONSTRUCTION OF MINOR, MINOR MISC. & NRM
ADA LOGISTICS
DIRECTOR, OFFICE OF CONSTRUCTION
PCBA
• CONST'N BUDGET
• SCHEDULE CONTROL
• MIS
RESIDENT ENGINEER STAFF
• ON SITE TECH SUPV (CONST'N)
SUPPORT STAFFS
• RESEARCH
• INFO SYS
• SPACE MGMT
SUPPORT STAFFS
• CONTRACT ADMINISTRATION
• AE EVALUATION
PROJ DIR (NE)
PROJ DIR (SOUTH)
PROJ DIR (CENTRAL)
PROJ DIR (WESTERN)
• DESIGN & CONSTRUCTION CONTRACT MGMT
AD PLANNING
• PROJECT PLANNING
• PROJECT MGMT
• ESTIMATING
• LAND MGMT
• HISTORIC PRESERVATION
AD ARCHITECTURE
• ARCH SERVICES
AD ENGINEERING
• ENGR DESIGN & CONST'N SERVICES (CIVIL, MECHANICAL & ELECTRICAL)

- The complexities involved in providing health care services, and the rapidly emerging changes in health care technology and the way services are provided. Improving medical service technologies and delivery modalities at the VAMCs require a construction process that is flexible and responsive to changing medical needs

- The special requirements for providing services in a federal government environment, where rigidities are built into many of the mechanisms required to obtain and utilize resources. Relatively long lead times required for obtaining federal construction resources and for obtaining A/E and construction contractor services require close working relationships between staff in the two programs throughout the early stages of the HCF Construction Process

- The characteristics of the population served by the VA--America's veterans--a population whose needs are changing as it grows older. As veterans gravitate toward more southern states, program strategies must change, and construction resources must be targeted as much as 10 years in advance of actual need in the health care program.

As with other types of resource management programs, health care facility construction must be closely integrated with health care program management to be effective in providing the resources to accomplish the VA mission.

(2) Weaknesses in Construction Policies and Procedures Limit the Effectiveness of Integration Between Health Care Facility Construction Management and Health Care Program Management

The coordination of health care facility construction initiatives with health care program management initiatives is hindered by three weaknesses in present construction policies and procedures:

- Unsystematic and poorly coordinated facility construction planning

- A lack of useful health care facility planning standards

- An absence of effective tools for managing performance in carrying out health care facility plans.

In the current HCF Construction Process, construction planning tends to focus on individual project needs rather than on more strategic facility development needs. This approach does not provide an adequate foundation for carrying out long-term planning. The result is inefficient utilization of resources, poorly coordinated construction activities at individual facilities, and ineffective project planning.

Another problem with the current approach to construction planning is that it fails to provide a mechanism for systematically addressing future facility needs. Through the current Medical District Initiated Planning Process (MEDIPP), long-range medical program needs are identified for the national health care program and programs at individual VAMCs, but implementation of those program directions is not well coordinated. Consistency of approaches, resulting from a definition first of strategic facility development requirements, is critical to effective coordination between the two processes.

Coordination at the individual construction project level is also hindered by facility planning standards that do not accurately reflect medical operating modalities. Standards have been developed, but a lack of explicitly defined assumptions about medical operating modalities, lack of definition within DM&S about medical operating modalities, and lack of agreement on operating modalities that have been developed, limit the usefulness of the standards as a starting point in facility planning. When facility planners attempt to adhere strictly to those standards, the result is facilities that do not meet the true needs of those who must provide services.

The lack of effective control tools for monitoring and evaluating performance results in construction delivery timeframes that are generally regarded as unacceptable by those involved in the HCF Construction Process. The effectiveness of the process in implementing health care program directions suffers.

(3) Coordination Is Hindered by the Placement of Oversight Responsibilities in the Office of Construction

One of the major findings of the Phase II data evaluation and analysis was the problem of excessive fragmentation of responsibilities for HCF Construction Process management. The analysis found that DM&S and O/C share responsibility for a number of management functions, including:

- Developing project plans for Major and Minor Construction projects
- Selecting and funding (program planning) Major and Minor Construction projects
- Monitoring and evaluating process performance in carrying out plans.

This fragmentation of process management functions has been purposely fostered in the current process to provide a check on DM&S in defining facility construction requirements and in carrying out projects to meet those requirements. O/C, in addition to its responsibility for supporting DM&S in performing these functions, is also responsible for "policing" them. Because O/C's capabilities are required by DM&S to carry out construction projects and because, through that involvement, O/C can ensure that requirements are not overstated, this structure does provide an effective check on the process.

The cost, however, is enormous. The performance of oversight and support functions in one organization is not compatible and results in conflicts among staff in O/C and between staff in DM&S and O/C in carrying out the process. The placement of oversight responsibility in O/C results in confusion over who is actually responsible for managing the process, a duplication of DM&S management control responsibilities, and a lack of clear accountability. In addition to poor performance in carrying out the HCF Construction Process, this organization creates tensions and conflict that result in poor coordination with the health care program.

The Phase II analysis demonstrated the importance of integration between the HCF Construction Process and the health care program. It also identified characteristics of current construction policies and procedures and organizational responsibilities that hinder integration. Phase III identified specific proposals and recommendations for changes to increase integration between health care construction and health care program management.

4. RECOMMENDATIONS MADE IN THIS STUDY REPRESENT A MAJOR STEP TOWARD BETTER INTEGRATION BETWEEN THE HEALTH CARE PROGRAM AND THE HCF CONSTRUCTION PROGRAM

Improving the current level of integration between the construction program and the health care program requires adjustments in the HCF Construction Process in two general areas:

- Construction policies and procedures that provide greater consistency with the health care program
- Organizational functional alignments that reduce coordination requirements between the two processes.

Phase III recommendations addressed improvements in both areas.

Two sets of recommendations have been developed. The first set addresses improvements in policies and procedures, which together comprise the core process. These recommendations include:

- Implementation of a facility development approach to construction planning that provides a strategic framework for identifying individual construction projects within a VAMC
- Development of earlier, more comprehensive project scope descriptions that provide necessary information for initiation of 5-year facility construction planning and project design activities
- Integration of the 5-year facility construction planning process with the MEDIPP to allow more effective construction planning within the context of health care program directions
- Establishment of better national office construction planning information that focuses attention on the achievement of health care facility construction goals and objectives

- Redefinition of design activities to stress the logical progression of design decisionmaking from the resolution of functional design issues to the resolution of technical design issues
- Development of funding strategies that minimize coordination requirements between the construction and budget processes to allow uninterrupted project design
- Development of facility design standards and control techniques that provide the necessary tools for project planning and overall process control.

These recommendations, if implemented, will provide the consistency required between construction program and health care program policies and procedures to achieve effective integration.

The second set of recommendations, which addresses the organization of responsibilities for carrying out the HCF Construction Process, includes:

- Consolidation of all planning functions currently performed by both O/C and DM&S into DM&S to increase accountability for establishing construction requirements
- Realignment of project control, process control, and process oversight responsibilities as follows:
  - Consolidation of project control responsibility at the VAMC level during project planning and during design and construction for Minor Construction/NRM projects; consolidation of project control responsibility in O/C during design and construction for Major Construction projects
  - Consolidation of all process control responsibility in DM&S
  - Consolidation of all process oversight responsibility in the Controller's Office
- Maintenance of O/C general responsibility for executing Major Construction projects and of VAMC exclusive responsibility for executing Minor Construction and NRM projects, with delegation of responsibility for Major Construction projects to VAMCs only on a case-by-case basis
- Consolidation of responsibility for functional standards (e.g., space criteria) and management information development in DM&S; consolidation of responsibility for technical (i.e., building system) standards development in O/C.

This organization establishes DM&S Central Office as the manager of the HCF Construction Process, O/C as the provider of technical support and Major Construction design and construction manager; and VAMCs as project planners and managers for Minor Construction/NRM projects.

* * * * *

While representing a major step toward full integration between the health care program and the construction program, recommendations made in this study stop short of full integration. They do so in recognition of the major change in focus that would be required to integrate the two programs. Moving too far, too fast, may result in serious disruptions of both programs, especially during a period when other reorganizations are taking place within DM&S. Full integration without necessary oversight mechanisms (now provided, in part, by O/C) could affect program integrity. The recommendations made in this report provide a major step forward that, if implemented, will establish the necessary foundation for full integration between the health care and construction programs. We recommend that the VA adopt, as its long-term goal, the development of a fully integrated HCF Construction Process.

Public Law 99-166
99th Congress

An Act

To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health-care programs, and for other purposes.

Dec. 3, 1985
[H.R. 505]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Veterans' Administration Health-Care Amendments of 1985.
38 USC 101 note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Administration Health-Care Amendments of 1985".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—HEALTH-CARE PROGRAMS

Sec. 101. Alcohol and drug treatment and rehabilitation.
Sec. 102. Special contract-care authority outside the 48 contiguous States.
Sec. 103. Extension of interim health-care eligibility based on exposure to dioxin or other toxic substances in Vietnam or to nuclear radiation.
Sec. 104. Outpatient and ambulatory services following nursing home or domiciliary care.
Sec. 105. Vietnam Veteran Resource Centers pilot program.
Sec. 106. Technical amendment relating to continuing availability of readjustment counseling.
Sec. 107. Counseling for former prisoners of war.
Sec. 108. Transfers for nursing home care.
Sec. 109. Chiropractic services pilot program.

TITLE II—HEALTH-CARE ADMINISTRATION

Sec. 201. Medical quality-assurance records.
Sec. 202. Authority to expand Geriatric Research, Education, and Clinical Centers program.
Sec. 203. Revision of authority for appointment of student nurses and graduate nurses.
Sec. 204. Quality assurance and credentialing.
Sec. 205. Availability of State financial support for approved State home projects.
Sec. 206. Procedures for reduction or revocation of clinical privileges.

TITLE III—VETERANS' ADMINISTRATION MEDICAL FACILITIES

Sec. 301. Clarification of requirement of congressional approval of construction and acquisition projects.
Sec. 302. Operational and construction planning requirement.
Sec. 303. Major facility prospectus requirement.
Sec. 304. Development of medical-facility modular components.
Sec. 305. Feasibility study of and plan for the purchase of a facility for furnishing hospital and nursing home care.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Servicemen's Group Life Insurance and Veterans' Group Life Insurance.
Sec. 402. Extension of authority to operate an office in the Republic of the Philippines.
Sec. 403. Veterans' Administration grade reduction.
Sec. 404. Land transfer, Phoenix, Arizona.
Sec. 405. Modification of restrictions on real property, Milwaukee County, Wisconsin.

TITLE IV—MISCELLANEOUS PROVISIONS—Continued

Sec. 406. Authority to release limitation on use of real property, McKinney, Texas.
Sec. 407. Modification of restrictions on real property and conveyance of a fence on such property, Salt Lake City, Utah.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—HEALTH-CARE PROGRAMS

SEC. 101. ALCOHOL AND DRUG TREATMENT AND REHABILITATION.

Ante, p. 481.
38 USC 620A.

(a) EXTENSION OF SPECIAL CONTRACT AUTHORITY.—Section 620A is amended—

(1) in subsection (a)(1)—

(A) by striking out "may conduct a pilot program under which the Administrator" in the first sentence; and

(B) by striking out the second sentence;

(2) by striking out "October 31, 1985" in subsection (e) and inserting in lieu thereof "September 30, 1988"; and

(3) by striking out subsection (f) and inserting in lieu thereof the following:

"(f)(1) The Administrator shall monitor the performance of each contract facility furnishing care and services under the program carried out under subsection (a) of this section.

"(2) The Administrator shall use the results of such monitoring to determine—

"(A) with respect to the program, the medical advantages and cost-effectiveness that result from furnishing such care and services; and

"(B) with respect to such contract facilities generally, the level of success under the program, considering—

"(i) the rate of successful rehabilitation for veterans furnished care and services under the program;

"(ii) the rate of readmission to contract facilities under the program or to Veterans' Administration health-care facilities by such veterans for care or services for disabilities referred to in subsection (a) of this section;

"(iii) whether the care and services furnished under the program obviated the need of such veterans for hospitalization for such disabilities;

"(iv) the average duration of the care and services furnished such veterans under the program;

"(v) the ability of the program to aid in the transition of such veterans back into their communities; and

"(vi) any other factor that the Administrator considers appropriate.

Records

"(3) The Administrator shall maintain records of—

"(A) the total cost for the care and services furnished by each contract facility under the program;

"(B) the average cost per veteran for the care and services furnished under the program; and

"(C) the appropriateness of such costs, by comparison to—

"(i) the average charges for the same types of care and services furnished generally by other comparable halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities; and

"(ii) the historical costs for such care and services for the period of time that the program carried out under subsection (a) of this section was a pilot program, taking into account economic inflation.

Report.

"(4) Not later than February 1, 1988, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the program carried out under this section during fiscal years 1984 through 1987. The report shall include—

"(A) a description of the care and services furnished;

"(B) the matters referred to in paragraphs (1), (2), and (3) of this subsection; and

"(C) the Administrator's findings, assessment, and recommendations regarding the program under this section.".

(b) CONFORMING AMENDMENTS.—(1) The heading for such section is amended by striking out the semicolon and the last two words.

(2) The item relating to such section in the table of sections at the beginning of chapter 17 is amended by striking out the semicolon and the last two words.

SEC. 102. SPECIAL CONTRACT-CARE AUTHORITY OUTSIDE THE 48 CONTIGUOUS STATES.

Puerto Rico.
Ante, p. 481.

(a) REVISION OF SPECIAL CONTRACT CARE AUTHORITY.—Section 601(4)(C)(v) is amended—

Alaska.
Hawaii.

(1) by striking out "(except with respect to Alaska and Hawaii) shall expire on October 31, 1985" and inserting in lieu thereof "with respect to the Commonwealth of Puerto Rico shall expire on September 30, 1988"; and

Virgin Islands.

(2) by striking out "and to the Virgin Islands".

Effective date.

(b) PHASE-OUT OF SPECIAL AUTHORITY IN PUERTO RICO.—(1) Effective on October 1, 1988, such section is amended—

(A) by inserting "(other than the Commonwealth of Puerto Rico)" after "in a State"; and

(B) by striking out "contiguous States" the second place it appears and all that follows through "medical services;" and inserting in lieu thereof "contiguous States and the Commonwealth of Puerto Rico;".

Prohibition.
38 USC 601 note.

(2) During fiscal year 1986, the obligations incurred for Puerto Rico contract care may not exceed 85 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(3) During fiscal year 1987, the obligations incurred for Puerto Rico contract care may not exceed 50 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(4) During fiscal year 1988, the obligations incurred for Puerto Rico contract care may not exceed 25 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(5) For the purpose of this subsection, the term "obligations incurred for Puerto Rico contract care" means the total obligations incurred during a fiscal year for medical services for veterans residing in the Commonwealth of Puerto Rico under the Administrator's authority to contract for hospital care or medical services under clause (v) of section 601(4)(C) of title 38, United States Code, in the Commonwealth of Puerto Rico.

SEC. 103. EXTENSION OF INTERIM HEALTH-CARE ELIGIBILITY BASED ON EXPOSURE TO DIOXIN OR OTHER TOXIC SUBSTANCES IN VIETNAM OR TO NUCLEAR RADIATION.

38 USC 610.

Section 610(e)(3) is amended by striking out "after the end of" and all that follows and inserting in lieu thereof "after September 30, 1989.".

SEC. 104. OUTPATIENT AND AMBULATORY SERVICES FOLLOWING NURSING HOME OR DOMICILIARY CARE.

Section 612(f)(1) is amended—

(1) by striking out "where" the first two places it appears and inserting in lieu thereof "if";

(2) by inserting a comma and "nursing home care, or domiciliary care" after "hospital care" the second place it appears;

(3) by striking out "hospital" the fourth place it appears; and

(4) by striking out "in-hospital" and inserting in lieu thereof "such".

SEC. 105. VIETNAM VETERAN RESOURCE CENTERS PILOT PROGRAM.

38 USC 612A.

Section 612A is amended by adding at the end the following new subsection:

"(h)(1) During the period beginning on January 1, 1986, and ending on September 30, 1988, the Administrator shall conduct a pilot program to provide and coordinate the provision of services described in paragraph (2) of this subsection. The pilot program shall be carried out in order to evaluate the effectiveness, feasibility, and desirability of providing veterans eligible for readjustment counseling under this section with additional services through facilities furnishing such counseling.

"(2) The services referred to in paragraph (1) of this subsection are—

"(A) counseling with respect to, and assistance in applying for, all benefits and services under laws administered by the Veterans' Administration for which veterans participating in the pilot program may be eligible;

Employment and unemployment.
38 USC 2003, 2003A.
Drugs and drug abuse.

"(B) employment counseling, training, placement, and related services described in sections 2003 and 2003A of this title or provided under any other law administered by the Secretary of Labor;

"(C) initial intake and referral services with respect to disabilities related to alcohol or drug dependence or abuse and follow-up services for veterans who have received treatment for such disabilities; and

"(D) assistance in coordinating the provision of benefits and services to veterans participating in the pilot program with respect to such veterans' receipt of—

"(i) services provided under the pilot program; and

"(ii) other benefits and services provided under laws administered by the Veterans' Administration, the Secretary of Labor, or any other Federal agency or official.

"(3)(A) In order to carry out the pilot program, the Administrator shall—

"(i) designate as sites for demonstration projects 10 facilities which on the date of the enactment of this section are providing readjustment counseling under this section; and

"(ii) assign such staff and other resources to such facilities as are necessary to enable such facilities to provide the services referred to in subparagraphs (A) and (C) of paragraph (2) of this subsection.

"(B) Facilities designated under subparagraph (A) of this paragraph shall be known as Vietnam Veteran Resource Centers (hereinafter in this subsection referred to as 'Centers').

"(4) The Administrator—

"(A) shall be responsible for coordinating the assignment and use of employees, on full- or part-time bases, as appropriate, in each Center; and

"(B) shall, in carrying out that responsibility, make maximum feasible use of the Veterans' Administration employees who are providing services at each facility on the date it is designated as a Center under this subsection.

"(5) The Secretary of Labor shall provide for the assignment to each Center, on full- or part-time bases, as the Secretary considers appropriate, of disabled veterans' outreach specialists appointed under section 2003A of this title or employees on the staffs of local employment service offices who are assigned to perform services under section 2004 of this title.

38 USC 2003A

38 USC 2004

"(6) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the pilot program during its first 15 months of operation. The report shall include—

Report

"(A) the Administrator's assessment of—

"(i) the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) of this subsection and counseling and services furnished under subsections (a) and (b) of this section; and

"(ii) the appropriateness of the use of the personnel assigned to the program;

"(B) a description of any administrative action that the Administrator plans to take generally to increase the coordination of the provision of such services to veterans eligible for readjustment counseling services under this section;

"(C) any recommendation that the Administrator considers appropriate; and

"(D) a comparison of such assessment, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by subsection (g)(2) of this section.

"(7) Not later than January 1, 1989, the Administrator shall submit to such Committees a final report on the pilot program. The report shall include—

Report

"(A) updates of all information provided in the report submitted pursuant to paragraph (6) of this subsection; and

"(B) the Administrator's final assessment of the pilot program based on 33 months of operation.".

SEC. 106. TECHNICAL AMENDMENT RELATING TO CONTINUING AVAILABILITY OF READJUSTMENT COUNSELING.

Section 612A(g)(1)(B) is amended by striking out "who requested counseling before such date" and inserting in lieu thereof "who request such counseling".

38 USC 612A

SEC. 107. COUNSELING FOR FORMER PRISONERS OF WAR.

(a) In General.—Subchapter II of chapter 17 is amended by inserting after section 612A the following new section:

38 USC 612B.

"§ 612B. Counseling for former prisoners of war

"The Administrator may establish a program under which, upon the request of a veteran who is a former prisoner of war, the Administrator, within the limits of Veterans' Administration facilities, furnishes counseling to such veteran to assist such veteran in overcoming the psychological effects of the veteran's detention or internment as a prisoner of war.".

(b) Clerical Amendment.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 612A the following new item:

"612B. Counseling for former prisoners of war.".

SEC. 108. TRANSFERS FOR NURSING HOME CARE.

38 USC 620.

(a) In General.—Subsection (a) of section 620 is amended to read as follows:

"(a)(1) Subject to subsection (b) of this section, the Administrator may transfer to a non-Veterans' Administration nursing home, for care at the expense of the United States—

"(A) a veteran—

"(i) who has been furnished hospital care, nursing home care, or domiciliary care by the Administrator in a facility under the direct jurisdiction of the Administrator; and

"(ii) who the Administrator determines—

"(I) requires a protracted period of nursing home care which can be furnished in the non-Veterans' Administration nursing home; and

"(II) in the case of a veteran who has been furnished hospital care in a facility under the direct jurisdiction of the Administrator, has received maximum benefits from such care; and

"(B) a member of the Armed Forces—

"(i) who has been furnished care in a hospital of the Armed Forces;

"(ii) who the Secretary concerned determines has received maximum benefits from such care but requires a protracted period of nursing home care; and

"(iii) who upon discharge from the Armed Forces will become a veteran.

"(2) The Administrator may transfer a person to a nursing home under this subsection only if the Administrator determines that the cost to the United States of the care of such person in the nursing home will not exceed—

"(A) the amount equal to 45 percent of the cost of care furnished by the Veterans' Administration in a general hospital under the direct jurisdiction of the Administrator (as such cost may be determined annually by the Administrator); or

"(B) the amount equal to 50 percent of such cost, if such higher amount is determined to be necessary by the Administrator (upon the recommendation of the Chief Medical Director) to provide adequate care.

Prohibition.

"(3) Nursing home care may not be furnished under this subsection at the expense of the United States for more than six months in the aggregate in connection with any one transfer except—

"(A) in the case of a veteran—

"(i) who is transferred to a non-Veterans' Administration nursing home from a hospital under the direct jurisdiction of the Administrator; and

"(ii) whose hospitalization was primarily for a service-connected disability;

"(B) in a case in which the nursing home care is required for a service-connected disability; or

"(C) in a case in which, in the judgment of the Administrator, a longer period of nursing home care is warranted.

Alaska
Hawaii

"(4) A veteran who is furnished care by the Administrator in a hospital or domiciliary facility in Alaska or Hawaii may be furnished nursing home care at the expense of the United States under this subsection even if such hospital or domiciliary facility is not under the direct jurisdiction of the Administrator.".

(b) ADMISSION TO CONTRACT NURSING HOMES OF CERTAIN VETERANS.—Subsection (d) of such section is amended—

(1) by inserting "(1)" after "(d)";

(2) by striking out "to any public or private institution not under the jurisdiction of the Administrator which furnishes nursing home care" in the first sentence and inserting in lieu thereof "to any non-Veterans' Administration nursing home";

(3) by inserting after the first sentence the following new sentence: "The Administrator may also authorize a direct admission to such a nursing home for nursing home care for any veteran who has been discharged from a hospital under the direct jurisdiction of the Administrator and who is currently receiving medical services as part of home health services from the Veterans' Administration.";

(4) by striking out the sentence beginning "Such admission" and inserting in lieu thereof the following:

Physicians.

"(2) Direct admission authorized by paragraph (1) of this subsection may be authorized upon determination of need therefor—

"(A) by a physician employed by the Veterans' Administration; or

"(B) in areas where no such physician is available, by a physician carrying out such function under contract or fee arrangement,

based on an examination by such physician."; and

(5) by designating the last sentence as paragraph (3).

(c) DEFINITION OF NON-VETERANS' ADMINISTRATION NURSING HOME.—Subsection (e) of such section is amended—

(1) by inserting "(1)" after "(e)";

(2) by striking out "subsection (a)(ii)" in the second sentence and inserting in lieu thereof "subsection (a)(2)(B)"; and

(3) by adding at the end the following:

"(2) For the purposes of this section, the term 'non-Veterans' Administration nursing home' means a public or private institution not under the direct jurisdiction of the Administrator which furnishes nursing home care.".

38 USC 3203 note.
98 Stat. 43.

(d) IMPROVEMENT IN PENSION PROGRAM ADMINISTRATION.—(1) In order to improve the timeliness of adjustments made pursuant to section 3203(a) of title 38, United States Code, in the amount of pension being paid to a veteran who is being furnished nursing home care by the Veterans' Administration, the Chief Medical Director of the Veterans' Administration shall develop improved procedures for notifying the Chief Benefits Director of the Veterans' Administration when a veteran is admitted to a nursing home.

Report

(2) The Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the development and implementation of such procedures. The report shall be submitted not later than 90 days after the date of the enactment of this Act.

38 USC 610 note

SEC. 109. CHIROPRACTIC SERVICES PILOT PROGRAM.

(a) ESTABLISHMENT OF PILOT PROGRAM.—(1) The Administrator of Veterans' Affairs shall conduct a pilot program to evaluate the therapeutic benefits and the cost-effectiveness of furnishing certain chiropractic services to veterans eligible for medical services under chapter 17 of title 38, United States Code. Such a veteran is eligible to receive chiropractic services under the pilot program if the veteran was furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine within the 12-month period immediately preceding the commencement of the furnishing of such chiropractic services.

38 USC 601 *et seq*

(2) The pilot program shall consist of not less than one demonstration project in each of five geographic regions of the United States designated by the Administrator for the purpose of this section.

(3) The pilot program shall be carried out during the period beginning on January 1, 1986, and ending on December 31, 1988.

(b) CONSULTATION AND COORDINATION.—In developing the pilot program, the Administrator shall consult with the Secretary of Defense regarding the demonstration projects carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note). In designing, conducting, and evaluating the pilot program, the Administrator shall obtain advice and recommendations from recognized medical or scientific authorities in the treatment of neuromusculoskeletal conditions of the spine. The Administrator shall ensure that there is adequate participation by chiropractors in the design and evaluation of the demonstration projects, including participation by representatives from chiropractic colleges recognized by an approved accrediting organization.

98 Stat. 2543

(c) PAYMENT FOR CHIROPRACTIC SERVICES UNDER THE PILOT PROGRAM.—(1)(A) The Administrator shall pay the reasonable charge for chiropractic services furnished to eligible veterans under the pilot program.

Insurance. Contracts.

(B) The Administrator may not pay for such services to the extent that the veteran is entitled to such services (or reimbursement for the expenses of such services) under—

(i) an insurance policy or contract;

(ii) a medical or hospital service agreement or membership or subscription contract; or

(iii) a similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

(2) The Administrator—

(A) shall reimburse the veteran for such reasonable charges if the veteran has paid for such services; or

(B) in lieu of reimbursing a veteran for a charge for chiropractic services under subparagraph (A), may pay the reasonable charge for such chiropractic services directly to the chiropractor who furnished the services.

(3) The amount paid for chiropractic services under this subsection may not exceed the amount for such services prescribed under the schedule of reasonable charges established under subsection (d).

Schools and colleges.

(4) Chiropractic services may be provided in private facilities or chiropractic colleges approved in guidelines issued by the Administrator.

Regulations.

(5) Reimbursement of veterans and payments to chiropractors under this subsection shall be carried out under regulations which the Administrator shall prescribe.

(d) Schedule of Reasonable Charges.—The Administrator shall establish a schedule of reasonable charges for chiropractic services furnished under the pilot program. Such schedule shall—

(1) be consistent with the reasonable charges allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u); and

(2) be established in consultation with—

(A) appropriate public and nonprofit private organizations; and

(B) other Federal departments and agencies that provide reimbursement for chiropractic services.

Prohibition.

(e) Program Cap.—The amount spent in any calendar year for chiropractic services under the pilot program may not exceed $2,000,000.

(f) Report.—Not later than April 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation, operation, and results of the pilot program. The report shall include—

(1) the number of requests made by eligible veterans for reimbursement or payment for chiropractic services under this section and the number of such veterans who made such requests;

(2) the number of such reimbursements and payments made and the number of veterans to (or for whom) such reimbursements and payments were made; and

(3) the total amount spent for such reimbursements and payments.

(g) Definitions.—For the purposes of this section:

(1) The term "chiropractic services" means the manual manipulation of the spine performed by a chiropractor to correct a subluxation of the spine. Such term does not include physical examinations, laboratory tests, radiologic services, and any other tests or services determined by the Administrator to be excluded.

(2) The term "chiropractor" means an individual who is licensed as such by the State in which the individual performs chiropractic services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5)).

TITLE II—HEALTH-CARE ADMINISTRATION

SEC. 201. MEDICAL QUALITY-ASSURANCE RECORDS.

Section 3305 is amended—

38 USC 3305.

(1) by inserting "(other than reports submitted pursuant to section 4152(b) of this title)" in subsection (a) after "program"; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of

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statistical information regarding Veterans' Administration health-care programs (including such information as aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities) that does not implicitly or explicitly identify individual Veterans' Administration patients or employees or individuals who participated in the conduct of a medical quality-assurance review.".

SEC. 202. AUTHORITY TO EXPAND GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS PROGRAM.

38 USC 4101

Section 4101(f)(1)(A) is amended by striking out "fifteen" and inserting in lieu thereof "25".

SEC. 203. REVISION OF AUTHORITY FOR APPOINTMENT OF STUDENT NURSES AND GRADUATE NURSES.

Section 4114(a)(3) is amended—

(1) by striking out "one year" in the second sentence of subparagraph (A) and inserting in lieu thereof "two years"; and

(2) by adding at the end the following new subparagraph:

"(C) A student nurse who has a temporary appointment under this paragraph and who is pursuing a full course of nursing in a recognized school of nursing approved by the Administrator may be reappointed for one year. Other personnel whose appointments are limited by this section to one year may not be reappointed under this subsection.".

SEC. 204. QUALITY ASSURANCE AND CREDENTIALING.

(a) IMPROVEMENTS IN PROGRAMS TO EVALUATE AND ASSURE HEALTH-CARE QUALITY.—(1) Chapter 73 is amended by adding at the end the following new subchapter:

"Subchapter V—Quality Assurance

38 USC 4151

"§ 4151. Quality assurance program

"(a) The Administrator shall—

"(1) establish and conduct a comprehensive program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery (hereinafter in this section referred to as the 'quality-assurance program'); and

"(2) delineate the responsibilities of the Chief Medical Director with respect to the quality-assurance program, including the duties prescribed in this section.

"(b)(1) As part of the quality-assurance program, the Chief Medical Director shall periodically evaluate—

"(A) whether there are significant deviations in mortality and morbidity rates for surgical procedures performed by the Department of Medicine and Surgery from prevailing national mortality and morbidity standards for similar procedures; and

"(B) if there are such deviations, whether they indicate deficiencies in the quality of health care provided by the Department of Medicine and Surgery.

"(2) The evaluation under paragraph (1)(A) of this subsection shall be made using the information compiled under subsection (c)(1) of this section. The evaluation under paragraph (1)(B) of this subsection shall be made taking into account the factors described in subsection (c)(2)(B) of this subsection.

"(3) If, based upon an evaluation under paragraph (1)(A) of this subsection, the Chief Medical Director determines that there is a deviation referred to in that paragraph, the Chief Medical Director shall explain the deviation in the next report submitted under section 4152 of this title. *Infra.*

"(c)(1) The Chief Medical Director shall—

"(A) determine the prevailing national mortality and morbidity standards for each type of surgical procedure performed by the Department of Medicine and Surgery; and

"(B) collect data and other information on mortality and morbidity rates in the Department of Medicine and Surgery for each type of surgical procedure performed by the Department and (with respect to each such procedure) compile the data and other information so collected—

"(i) for each medical facility of the Veterans' Administration, in the case of cardiac surgery, heart transplant, and renal transplant programs; and

"(ii) in the aggregate, for each other type of surgical procedure.

"(2) The Chief Medical Director shall—

"(A) compare the mortality and morbidity rates compiled under paragraph (1)(B) of this subsection with the national mortality and morbidity standards determined under paragraph (1)(A) of this subsection; and

"(B) analyze any deviation between such rates and such standards in terms of—

"(i) the characteristics of the respective patient populations;

"(ii) the level of risk for the procedure involved, based on—

"(I) patient age;

"(II) the type and severity of the disease;

"(III) the effect of any complicating diseases; and

"(IV) the degree of difficulty of the procedure; and

"(iii) any other factor that the Chief Medical Director considers appropriate.

"(d) Based on the information compiled and the comparisons, analyses, evaluations, and explanations made under subsections (b) and (c) of this section, the Chief Medical Director, in each report under section 4152 of this title, shall make such recommendations with respect to quality assurance as the Chief Medical Director considers appropriate.

"(e)(1) The Administrator shall allocate sufficient resources (including sufficient personnel with the necessary skills and qualifications) to enable the Department of Medicine and Surgery to carry out its responsibilities under this section.

"(2) The Inspector General of the Veterans' Administration shall allocate sufficient resources (including sufficient personnel with the necessary skills and qualifications) to enable the Inspector General to monitor the quality-assurance program.

"§ 4152. Quality-assurance reports 38 USC 4152.

"(a)(1) Not later than February 1 of 1987, 1989, and 1991, the Chief Medical Director shall submit to the Administrator a report on the experience through the end of the preceding fiscal year under the quality-assurance program carried out under section 4151 of this title. *Ante*, p. 950.

"(2) Each such report shall include—

"(A) the data and other information compiled and the comparisons, analyses, and evaluations made under subsections (b) and (c) of such section with respect to the period covered by the report; and

"(B) recommendations under subsection (d) of such section.

"(b) Not later than 60 days after receiving each such report, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comment concerning the report that the Administrator considers appropriate.

"(c) A report submitted under subsection (b) of this section shall not be considered to be a record or document as described in section 3305(a) of this title.".

38 USC 3305

(2) The table of sections at the beginning of chapter 73 is amended by adding at the end the following:

"SUBCHAPTER V—QUALITY ASSURANCE

"4151. Quality assurance program.
"4152. Quality-assurance reports.".

(b) Report on Credentials of Health-Care Professionals.—(1) The Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing in detail the current efforts and procedures and future plans of the Veterans' Administration for determining and monitoring the credentials of health-care professionals in connection with their furnishing care to veterans under chapter 17 of title 38, United States Code.

38 USC 601 *et seq*

(2)(A) The report shall include a description of each current and planned Veterans' Administration policy or procedure regarding, or arrangement for, credentialing information exchanges.

(B) With reference to any such policy, procedure, or arrangement that is planned and has not been implemented at the time the report required by paragraph (1) is submitted, the Administrator shall—

(i) include in the report a timetable for such implementation; and

(ii) report to the committees on progress toward such implementation every three months thereafter until implementation of each such policy, procedure, and arrangement is achieved.

Upon implementation of each such policy, procedure, and arrangement, a final report on such implementation shall be submitted to the Committees.

(3) For the purposes of this subsection, the term "credentialing information exchanges" includes the exchange of relevant information with a license issuing or monitoring entity—

(A) in order to determine, with respect to an individual who is seeking employment with, or who is employed by, the Veterans' Administration as a health-care professional for the furnishing of care to veterans under chapter 17 of title 38, United States Code—

(i) whether the individual has completed medical or other health-care professional education satisfactorily;

(ii) the current and past licensure and clinical privilege status of the individual; or

(iii) the full employment history of the individual; or

(B) in order to provide appropriate information to such an entity about an individual whose employment with the Veterans' Administration as a health-care professional is terminated—

(i) following the completion of a disciplinary action relating to such individual's clinical competence;

(ii) voluntarily after having had such individual's clinical privileges restricted or revoked; or

(iii) voluntarily after serious concerns about such individual's clinical competence have been raised but not resolved.

(4) For the purposes of this subsection, the term "license issuing or monitoring entity" means—

(A) an appropriate State medical or other health-professional licensing body;

(B) the Federation of State Medical Boards;

(C) the American Medical Association; and

(D) any other public or private entity that the Administrator considers appropriate that is involved with the issuance or monitoring of health-care professional licenses.

Report.

(5) The report required by this subsection shall be submitted not later than 90 days after the date of the enactment of this Act.

SEC. 205. AVAILABILITY OF STATE FINANCIAL SUPPORT FOR APPROVED STATE HOME PROJECTS.

98 Stat. 2689.
38 USC 5035.

(a) DEADLINE FOR AVAILABILITY OF STATE CONSTRUCTION FUNDS.—Subsection (a)(6) of section 5035 is amended by inserting "by July 1 of the fiscal year for which the application is approved" before "and for its maintenance".

(b) DEFERRAL OF CERTAIN APPLICATIONS.—Subsection (b) of such section is amended—

(1) by inserting "(1)" after "(b)";

(2) by redesignating clauses (1) through (4) as clauses (A) through (D), respectively; and

(3) by adding at the end the following new paragraph:

"(2)(A) The Administrator shall defer approval of an application that meets the requirements of this section if the State submitting the application does not, by the July 1 deadline (as defined in subparagraph (C) of this paragraph), demonstrate to the satisfaction of the Administrator that the State has provided adequate financial support for construction of the project.

"(B) In a case in which approval of an application is deferred under subparagraph (A) of this paragraph—

Grants.
Nursing home.

"(i) the Administrator, in accordance with guidelines established by the Administrator, shall select for award of a grant or grants under this section an application or applications for a nursing home project or projects that the Administrator determines—

"(I) to be most in need;

"(II) would, but for the deferral, not have been approved during the fiscal year in which the deferral occurred; and

"(III) have been provided adequate financial support by the State and are otherwise qualified for approval during the fiscal year; and

"(ii) during the next fiscal year, the application with respect to which approval was deferred shall be accorded priority for approval ahead of applications that had not been approved before the first day of such fiscal year.

"(C) For the purposes of this paragraph, the term 'July 1 deadline' means July 1 of the fiscal year in which the State is notified by the Administrator of the availability of funding for a grant for such project.".

SEC. 204. PROCEDURES FOR REDUCTION OR REVOCATION OF CLINICAL PRIVILEGES.

38 USC 4110 note

(a) GUIDELINES.—Not later than April 1, 1986, the Administrator of Veterans' Affairs shall prescribe uniform guidelines establishing administrative procedures to be followed in any case in which a reduction or revocation of the clinical privileges of any person employed in a position described in paragraph (1) of section 4104 of title 38, United States Code, is proposed on the basis of a deficiency in the employee's performance of professional responsibilities.

(b) REPORT.—Not later than May 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report (containing a copy of such guidelines) on the implementation of this section.

TITLE III—VETERANS' ADMINISTRATION MEDICAL FACILITIES

SEC. 301. CLARIFICATION OF REQUIREMENT OF CONGRESSIONAL APPROVAL OF CONSTRUCTION AND ACQUISITION PROJECTS.

38 USC 5004.

Subsection (a) of section 5004 is amended to read as follows:

"(a)(1) The purpose of this subsection is to enable Congress to ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility.

"(2) After the adoption by the committees during a fiscal year of resolutions with identical texts approving major medical facility projects, it shall not be in order in the House of Representatives or in the Senate to consider a bill, resolution, or amendment making an appropriation for that fiscal year or for the next fiscal year which may be expended for a major medical facility project—

"(A) if the project for which the appropriation is proposed to be made is not approved in those resolutions; or

"(B) in the event that the project is approved in the resolutions, if either—

"(i) the bill, resolution, or amendment making the appropriation does not specify—

"(I) the medical facility project for which the appropriation is proposed to be made; and

"(II) the amount proposed to be appropriated for the project; or

"(ii) the amount proposed to be appropriated for the project (when added to any amount previously appropriated for the project) exceeds the amount approved for the project.

Prohibition

"(3) No appropriation may be made for the lease of any space for use as a medical facility at an average annual rental of more than $500,000 unless each committee has first adopted a resolution approving such lease and setting forth the estimated cost thereof.

"(4) For the purpose of this subsection, the term 'major medical facility project' means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $2,000,000. Such term does not include an acquisition by exchange.".

SEC. 302. OPERATIONAL AND CONSTRUCTION PLANNING REQUIREMENT.

(a) REQUIREMENT FOR IMPROVED PLANNING.—Subsection (a) of section 5007 is amended— 38 USC 5007.

(1) by inserting "(1)" after "(a)";

(2) by striking out "and alteration" the second place it appears in the first sentence and inserting in lieu thereof "alteration, and operation";

(3) by striking out the second and third sentences; and

(4) by adding at the end the following new paragraphs:

"(2) Each such report shall contain— Report.

"(A) a five-year strategic plan for the operation and construction of medical facilities—

"(i) setting forth—

"(I) the mission of each existing or proposed medical facility;

"(II) any planned change in such mission; and

"(III) the operational steps needed to achieve the facility's mission and the dates by which such steps are planned to be completed; and

"(ii) a five-year plan, based on the factors set out in subclause (i) of this clause, for construction, replacement, or alteration projects for each such facility;

"(B) a list, in order of priority, of not less than 10 hospitals that, in the judgment of the Administrator, are most in need of construction or replacement; and Hospitals.

"(C) general plans (including projected costs, site location, and, if appropriate, necessary land acquisition) for each medical facility for which construction, replacement, or alteration is planned under clause (A)(ii) of this paragraph.

"(3) The report under this subsection shall be submitted not later than June 30 of each year.". Report.

(b) TECHNICAL AMENDMENTS.—Subsection (b) of such section is amended—

(1) by striking out "(beginning in 1981)";

(2) by inserting "(1)" after "medical facility"; and

(3) by striking out "title and, in the case of the second and each succeeding report made under this subsection," and inserting in lieu thereof "title, and (2)".

(c) CLERICAL AMENDMENTS.—(1) The heading for such section is amended to read as follows:

"§ 5007. Operational and construction plans for medical facilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5007. Operational and construction plans for medical facilities.".

SEC. 303. MAJOR FACILITY PROSPECTUS REQUIREMENT.

Section 5004(b)(1) is amended by inserting "and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a description of the consideration that was given to 38 USC 5004.

acquiring an existing facility by lease or purchase" after "such facility".

38 USC 5003 note.

SEC. 304. DEVELOPMENT OF MEDICAL-FACILITY MODULAR COMPONENTS.

In order to evaluate the applicability to the Veterans' Administration of the use of modular components in the design and construction of medical facilities for the furnishing of hospital care and to determine the efficiency and cost-effectiveness of that approach, the Administrator of Veterans' Affairs shall, not later than one year after the date of the enactment of this Act, develop a modular approach to the planning and design of an appropriate Veterans' Administration medical facility for the furnishing of hospital care.

SEC. 305. FEASIBILITY STUDY OF AND PLAN FOR THE PURCHASE OF A FACILITY FOR FURNISHING HOSPITAL AND NURSING HOME CARE.

President of U.S. Florida.

98 Stat. 2324.

In the documents submitted by the Administrator of Veterans' Affairs to the appropriate committees of the Congress at the time of and in connection with the submission, pursuant to section 1105 of title 31, United States Code, of the Budget for fiscal year 1987, the Administrator shall include the results of a feasibility study which he shall conduct of, and if indicated by such study provide a feasibility plan for, the purchase for Veterans' Administration use of a medical facility that is located in an urban area and is suitable for furnishing both hospital and nursing home care services, and meets the current and projected needs and specifications of the Veterans' Administration for furnishing health care to eligible veterans. In such Budget, the President, as warranted by such feasibility plan, shall include a request for an appropriate amount to purchase such a facility which meets those needs and specifications: *Provided*, That this section shall not be construed to require the Administrator to provide a feasibility plan with respect to the purchase of a facility that would have the effect of making it infeasible to construct, acquire, or lease a medical facility in the Florida panhandle or to expand the Biloxi/Gulfport Veterans' Administration Medical Center to furnish health care to veterans in the area.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. SERVICEMEN'S GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE.

38 USC 767.

(a) SERVICEMEN'S GROUP LIFE INSURANCE.—(1) Subsection (a) of section 767 is amended—

(A) by striking out "$35,000" and inserting in lieu thereof "$50,000"; and

(B) by striking out "the amount of $30,000, $25,000, $20,000, $15,000, $10,000 or $5,000" and inserting in lieu thereof "an amount less than $50,000 that is evenly divisible by $10,000".

(2) Subsection (c) of such section is amended by striking out "the amount of" the first place it appears and all that follows through "as the case may be," and inserting in lieu thereof "any amount less than $50,000, such member may thereafter be insured under this subchapter in the amount of $50,000 or any lesser amount evenly divisible by $10,000".

(3) Subsection (d) of such section is amended—

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(A) by striking out "the effective date of this subsection" each place it appears and inserting in lieu thereof "January 1, 1986"; and

(B) by striking out "up to a maximum of $35,000 (in any amount divisible by $5,000)" and inserting in lieu thereof "in the amount of $50,000 or any lesser amount evenly divisible by $10,000".

(b) Veterans' Group Life Insurance.—(1) Subsection (a) of section 777 of such title is amended— 38 USC 777.

(A) by striking out the first sentence and inserting in lieu thereof the following: "Veterans' Group Life Insurance shall be issued in the amounts specified in section 767(a) of this title. In the case of any individual, the amount of Veterans' Group Life Insurance may not exceed the amount of Servicemen's Group Life Insurance coverage continued in force after the expiration of the period of duty or travel under section 767(b) or 768(a) of this title."; and

Ante, p. 956.

38 USC 767; 768.

(B) by striking out "$35,000" in the sentence immediately following the matter inserted by clause (A) and both places it appears in the last sentence and inserting in lieu thereof "$50,000".

(2) Such section is further amended by adding at the end the following new subsection:

Individual Ready Reserve.
Inactive National Guard.

"(h)(1) Notwithstanding any other provision of law, members of the Individual Ready Reserve and the Inactive National Guard are eligible to be insured under Veterans' Group Life Insurance. Any such member shall be so insured upon submission of an application in the manner prescribed by the Administrator and the payment of premiums as required under this section.

"(2) Notwithstanding subsection (b)(2) of this section, Veterans' Group Life Insurance coverage under this subsection shall be issued on a renewable five-year term basis, but the person insured must remain a member of the Individual Ready Reserve or Inactive National Guard throughout the period of the insurance in order for the insurance of such person to be renewed.

"(3) For the purpose of this subsection, the terms 'Individual Ready Reserve' and 'Inactive National Guard' shall have the meanings prescribed by the Administrator in consultation with the Secretary of Defense.".

(c) Effective Date.—The amendments made by subsections (a) and (b) shall take effect on January 1, 1986. 38 USC 767 note.

SEC. 402. EXTENSION OF AUTHORITY TO OPERATE AN OFFICE IN THE REPUBLIC OF THE PHILIPPINES.

Section 230(b) is amended by striking out "October 31, 1985" and inserting in lieu thereof "September 30, 1988". *Ante*, p. 481.

SEC. 403. VETERANS' ADMINISTRATION GRADE REDUCTION.

(a) Section 210(b) is amended by adding at the end the following new paragraphs: 38 USC 210.

"(3)(A) The Administrator may not implement a grade reduction described in subparagraph (B) of this paragraph unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing a detailed plan for such reduction and a detailed justification for the plan. Such report shall include a determination by the Administrator (together with data supporting such determination) that, in the

Report.

Effective date.

personnel area concerned, the Veterans' Administration has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to the number of such employees at the salary levels involved who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any grade reduction described in such report may not take effect until the end of a period of 90 calendar days (not including any day on which either House of Congress is not in session) after the report is received by the committees.

"(B) A grade reduction referred to in subparagraph (A) of this paragraph is a systematic reduction, for the purpose of reducing the average salary cost for Veterans' Administration employees described in subparagraph (C) of this paragraph, in the number of such Veterans' Administration employees at a specific grade level.

"(C) The employees referred to in subparagraph (B) of this paragraph are—

"(i) health-care personnel who are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services;

"(ii) individuals who meet the definition of professional employee as set forth in section 7103(a)(15) of title 5; and

"(iii) individuals who are employed as computer specialists.

Report.

"(D) Not later than the forty-fifth day after the Administrator submits a report under subparagraph (A) of this paragraph, the Comptroller General shall submit to such Committees a report on the Administrator's compliance with such subparagraph. The Comptroller General shall include in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination (and of the data supporting such determination) made under such subparagraph.

Prohibition.

"(E) In the case of Veterans' Administration employees not described in subparagraph (C) of paragraph (3), the Administrator may not in any fiscal year implement a systematic reduction for the purpose of reducing the average salary cost for such Veterans' Administration employees that will result in a reduction in the number of such Veterans' Administration employees at any specific grade level at a rate greater than the rate of the reductions systematically being made in the numbers of employees at such grade level in all other agencies and departments of the Federal Government combined.".

Real property.

SEC. 404. LAND TRANSFER, PHOENIX, ARIZONA.

(a) Requirement for Transfer.—The real property described in subsection (b) and the structures on such property on the date of the enactment of this Act shall be transferred without compensation or reimbursement from the control and jurisdiction of the General Services Administration to the control and jurisdiction of the Veterans' Administration.

(b) Description of Land.—The real property referred to in subsection (a) is a tract of land consisting of 3.4 acres, more or less, in Phoenix, Arizona, that—

(1) was formerly part of the Veterans' Administration Medical Center, Phoenix, Arizona; and

(2) was declared to be excess to the needs of the Veterans' Administration in a report to the General Services Administration dated September 25, 1959.

SEC. 405. MODIFICATION OF RESTRICTIONS ON REAL PROPERTY, MILWAUKEE COUNTY, WISCONSIN.

(a) Release of Reversionary Interest.—The Administrator of Veterans' Affairs shall execute such instruments as may be necessary to modify the conditions under which the land described in subsection (b) will revert to the United States in order to permit Milwaukee County, Wisconsin, to lease all or part of such land to a nonprofit corporation which—

(1) shall construct and equip on such land structures, facilities, and other permanent improvements useful for public recreational purposes or general civic purposes; and

(2) shall use such land for such recreational or civic purposes.

(b) Description of Land.—The land referred to in subsection (a) is—

(1) the land conveyed to Milwaukee County, Wisconsin, pursuant to the Act entitled "An Act to authorize the Administrator of Veterans' Affairs to convey lands and to lease certain other land to Milwaukee County, Wisconsin", approved September 1, 1949 (63 Stat. 683); and

(2) the land conveyed to Milwaukee County, Wisconsin, pursuant to the Act entitled "An Act authorizing the Administrator of Veterans' Affairs to convey certain property to Milwaukee County, Wisconsin", approved August 27, 1954 (68 Stat. 866).

(c) General Limitations.—The Administrator may carry out this section subject to such terms and conditions (including reservations of rights for the United States) as the Administrator determines to be necessary to protect the interests of the United States.

SEC. 406. AUTHORITY TO RELEASE LIMITATION ON USE OF REAL PROPERTY, McKINNEY, TEXAS.

(a) Release of Limitation.—The Administrator of Veterans' Affairs shall execute such instruments as may be necessary to release the limitation to recreational purposes only on the use of the land described in subsection (b).

(b) Description of Land.—The land referred to in subsection (a) is two parcels of land, consisting of a total of 38.741 acres, that were conveyed by the Administrator to the city of McKinney, Texas, by deed of May 5, 1965, under the authority of Public Law 88-438 (78 Stat. 444, approved August 14, 1964).

SEC. 407. MODIFICATION OF RESTRICTIONS ON REAL PROPERTY AND CONVEYANCE OF A FENCE ON SUCH PROPERTY, SALT LAKE CITY, UTAH.

(a) Modification of Restriction.—(1) The Administrator of Veterans' Affairs shall execute such instruments as may be necessary in order to authorize the land conveyed under the authority of the Act referred to in paragraph (3) to be used—

(A) without regard to any limitation required by section 2 of that Act, but

68 Stat. 580

(B) subject to the limitations set forth in paragraph (2).

(2) Any instrument executed under paragraph (1) shall provide, with respect to the tract of land conveyed under the Act referred to in paragraph (3)—

(A) that such tract may be used only for hospital, educational, civic, residential, or related purposes;

(B) that, if any part of such tract is used in any manner that is determined by the Administrator to interfere with the care and treatment of any patient at a Veterans' Administration health-care facility located in the reservation described in such Act, such use shall cease immediately upon notice by the Administrator of such interference to the person holding legal title to such part at the time such use occurs;

(C) that, if any part of such tract is used for a purpose other than a purpose prescribed in clause (A), title to such part shall revert to the United States; and

(D) that, if any interference referred to in clause (B) does not cease as required under such paragraph, title to the part of such land that is being used in a manner to cause such interference shall revert to the United States.

Any such instrument may contain such additional terms and conditions (including reservations of rights to the United States) as the Administrator determines to be necessary to protect the interests of the United States.

(3) The Act referred to in paragraphs (1) and (2) is the Act entitled "An Act authorizing the Administrator of Veterans' Affairs to convey certain property to the Armory Board, State of Utah", approved July 29, 1954 (68 Stat. 579).

(b) CONVEYANCE OF FENCE.—The Administrator shall convey, without consideration, to the Armory Board of the State of Utah all right, title, and interest of the United States in the fence erected as required by the quitclaim deed issued to the Armory Board by the Administrator on October 14, 1954, under the authority of the Act referred to in subsection (a)(3). The conveyance shall contain such terms and conditions as the Administrator determines to be necessary to protect the interests of the United States.

Approved December 3, 1985.

LEGISLATIVE HISTORY—H.R. 505 (S. 876):

HOUSE REPORT No. 99-114 (Comm. on Veterans' Affairs).
SENATE REPORT No. 99-101 accompanying S. 876 (Comm. on Veterans' Affairs).
CONGRESSIONAL RECORD, Vol. 131 (1985):
    May 21, considered and passed House.
    July 30, considered and passed Senate, amended, in lieu of S. 876.
    Oct. 30, House concurred in Senate amendments with amendment.
    Nov. 6, 13, Senate concurred in House amendment with amendment.
    Nov. 14, House concurred in Senate amendments.

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